

# PUBLIC HEALTH

LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH  
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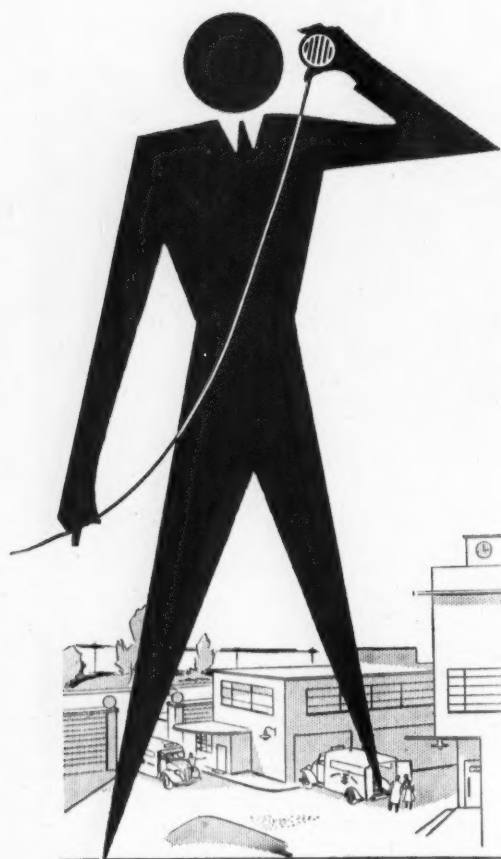
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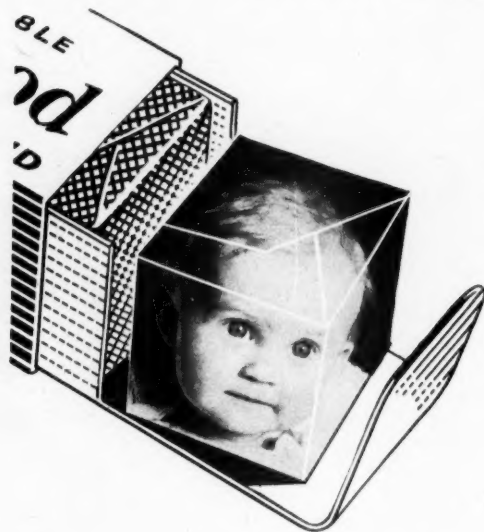
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## EDITORIAL

### Prospect for Assistant Medical Officers

The latest award of the Industrial Court (No. 2452, dated May 28th, 1953) makes a belated recognition of the facts that assistants of departmental medical officers are the clinical mainstay of preventive and educational health services, that many of them by choice make their careers in this field, and that they are the major source of recruitment for Medical Officers of Health and other senior administrative officers. Those who still complain that this award compares unfavourably with the Danckwerts award and the Spens recommendations for general practitioners must remember the very real advantages of sessional public health work—it is the M.O.H.s and their deputies who get the night calls of council and committee meetings—and moreover there are now many senior assistant posts open to those who wish to remain in clinical work rather than to turn to the higher rewards and more onerous duties of administration. It must be remembered that the sessional fee for practitioners undertaking work at local authority clinics is still 45s. so that 11 sessions a week for 48 weeks carried out by G.P. part-timers would cost the employing authority £1,188 p.a. This is really the figure by which the whole-time assistant medical officers' scale should be adjudged although it must be recognised that the Danckwerts award may yet be reflected in an upward adjustment in fees for individual sessions.

Observing the difficulties of making a case for an increase at a time of natural stringency and in the face of opposition from employers who are highly rates-sensitive, we think that this award is better than might have been expected, though not more than the recipients deserve. It implies that the tribunal accepted the contention of the B.M.A. that Public Health Medical Officers are first and foremost doctors who elect to take up this branch of practice. This was not clearly established by the previous awards and on that ground alone we think the negotiators for the staff side and their counsel have gained a major point. There remain some glaring anomalies in the application of the other scales but the effect of the present award at least lessens the gap for those who hold mixed appointments in countries where there is no divisional or area M.O. grade.

### Health and Housing in Liverpool

We are glad to publish in this issue Dr. R. Bradbury's address to the North-Western Branch of the Society on slum clearance in Liverpool, not only because it conveys the wisdom of a leading authority on housing and town planning but also because it contains a warm tribute to Prof. W. M. Frazer, whose retirement as Medical Officer of Health for the City had taken place a week earlier. In his last annual report, that for 1951, Prof. Frazer includes an interesting account of his 21 years as M.O.H., Liverpool, which brings out his continuous active interest in housing and slum clearance as major problems in that city—for instance, the survey made in 1936, following the Housing Act, 1935, revealed that of all the working-class houses in the city 7.43% were overcrowded by the definition now made for the first time, though overcrowding had been a statutory nuisance since the Public Health Act of 1875. Great progress has been made by the combined efforts of the housing and health departments, and the corporation's modern dwellings have replaced much of the legacy of the 19th century.

If we may pick out one other feature of Prof. Frazer's account, it is his development of the hospitals of the area both before and after the appointed day in 1948. He was, of course, the only serving M.O.H. appointed (in his academic capacity) as a member of a Regional Hospital Board and he firmly believes in consultation and close co-operation between hospital and health authorities. The Liverpool Region has been notably successful in these respects, not least, we believe, because of Prof. Frazer's presence on the Board.

His story reminds us of Prof. E. W. Hope and Dr. Mussen, his predecessors, and of distinguished colleagues, such as Drs. Hanna, Stallybrass and B. J. T. Glover, to mention only a few. His concluding words must give him real satisfaction in his retirement, and something for his successor, Dr. Andrew Semple, to aim at: "Liverpool is a much healthier city than it was in 1931, judged by every possible test. There is still, however, a great deal to be done."

# PAST AND PRESENT DUTIES OF MEDICAL OFFICERS OF HEALTH But What of the Future?\*

By J. B. S. MORGAN, B.Sc., M.B., D.P.H.,  
*County Medical Officer of Health, Derby*

I wish to be deliberately provocative, in order to stimulate discussion at the end of the address. It has been said that there is only one thing that is constant in life, and that is change, and this may be said with particular force of the duties of a Medical Officer of Health. It is well, however, to cast a glance back on the road that we have travelled, because this often helps in determining in which direction we should proceed.

Liverpool was the first Authority to appoint a Medical Officer of Health, Dr. W. H. Duncan, who took up duty in that capacity on January 1st, 1847. Further appointments were made from time to time as the large towns became more conscious of the health of their communities. The appointment of Medical Officers of Health by all local authorities was made compulsory in 1872. The Local Government Act, 1888, set up County Councils on an elective basis, and instituted a new class of County Boroughs, expressly exempted from the jurisdiction of the newly appointed County Councils, which otherwise were given certain supervisory powers over the districts within their borders. The Act also empowered the newly created County Councils to appoint Medical Officers of Health and made compulsory the possession of a registered Diploma in Public Health (or its equivalent) in the case of a County Medical Officer of Health.

The first Medical Officers of Health were concerned generally with water supplies and sewage disposal, because of the importance of these matters in the control of infections, and isolation hospitals were built to segregate patients.

I would remind you of some of the duties and powers that County and County Borough Councils have been charged with in connection with the medical services over the years.

The Education (Administrative Provisions) Act, 1907, required authorities to set up a regular system of medical inspection and empowered them to provide certain types of treatment. From then onwards a system of increasing medical inspection and care of the health of the child has been steadily built up through the provisions of the Education Act of 1921 and, latterly, the Education Act of 1944, which requires Education Authorities to make sure that children can get and are encouraged to get all forms of medical and hospital care, and to maintain their arrangements for medical inspection of children, although treatment has largely been removed from their province by the National Health Service Act, of 1946.

In 1911 local authorities were required to establish institutions for the treatment of tuberculosis, a requirement now placed on Regional Hospital Boards by the 1946 Act.

In 1913 County and County Borough Councils were empowered to make provision for the care of mental defectives. Institutional provision is now the responsibility of Regional Hospital Boards, while the local authorities continue to exercise care of the mental defective in the community.

In 1916 the duty of combating venereal diseases was placed on County and County Borough Councils. Treatment, however, is now the responsibility of the Hospital Boards.

In 1918 came legislation for meeting the needs of expectant and nursing mothers and children under five years of age, and these provisions, made obligatory in the National Health Service Act, remain the responsibility of the local authorities.

The Local Government Act, 1929, abolished the Boards of Guardians, but not the Poor Law. Under that Act, the Medical Officer of Health had considerable work in attempting the unification of the medical services and their development, including the hospital side. Those institutions, however, are now governed wholly or partly by the terms of the National Assistance Act, 1948, or the National Health Service Act.

In 1936 the major health authorities were required to provide a domiciliary midwifery service either by employing a number of full-time midwives or in some cases by making arrangements with existing District Nursing Associations, and continue to do so.

I would, however, like to refer particularly to certain Acts that have come into operation since the war—the Children Act, 1948; the National Assistance Act, 1948; the Education Act, 1944; and the National Health Service Act, 1946—with respect to which the Medical Officer of Health has some responsibilities.

## (i) *The Children Act, 1948*

The Children Act was an instance of "panic legislation" as it arose through one case which should never have happened and shows the danger of generalising from the particular. It was clear from the Curtis Report that health visitors employed by health departments before the Act came into operation were not criticised, but rather commended for their good work in supervising children deprived of a normal home life. I believe that the new Children's Departments are doing their work very well; but the creation of a separate Department has given rise to the expenditure of a great deal of money unnecessarily, through the duplication of similar services that were already provided by the Health Departments.

## (ii) *The National Assistance Act, 1948*

The responsibilities of County Councils and County Borough Councils under Part III of the National Assistance Act should be placed on their respective Health Departments, for the following reasons:—

1. The responsibility for ascertaining and supervising the whole range of handicapped pupils is placed on Health Departments when the Medical Officer of Health is also the School Medical Officer—which he is with rare exceptions. The work requires a medical knowledge and medical officers approved by the Ministry of Education are employed, assisted by school nurses who are in many instances qualified health visitors. It is a waste of these trained officers' time not to make use of their services when patients cease to be of school age, because if a separate Welfare Department is set up it cannot hope to possess these highly trained officers.

2. Up to July, 1948, Health Departments were responsible in most cases for the ascertainment of the blind of all ages and for their welfare.

3. The Health Department already provides a Home Nursing Service, a Domestic Help Service, and a Health Visiting Service, and is responsible for the prevention and the care and after-care of illness. Many of these services are required by the handicapped and the elderly. (It is well-known that the elderly are often fit one day and ill the next.) It seems wasteful to set up a separate department to deal only with the latter when there is such a wide range of services available through the Health Department.

4. One authority at least has appointed its Medical Officer of Health as Civic Welfare Officer in charge of the Welfare Department. That is not sufficient liaison. There should be one Health Department under the

\* Presidential address to the East Midland Branch, Society of M.O.H., Nottingham, October 9th, 1952.

Medical Officer of Health so that there is a "tie-up" between the welfare and health services at all levels.

5. Some authorities have placed the responsibility for only certain sections of Part III of the National Assistance Act on the Health Department. This is insufficient. The whole range of welfare should be taken over by the Health Department—the rough with the smooth. To deal with it in any other way would lead to confusion, not only between the various departments in local government, but also in the minds of the general public when they need information.

6. It is true that the advice of Medical Officers of Health is sought by the Welfare Departments on many matters, which advice is readily given; but unfortunately in a large number of instances when medical advice should be obtained it is not sought. If the responsibility for the Welfare Services was placed on the Medical Officer of Health, with his medical knowledge, this disadvantage would disappear.

### (iii) *The Education Act, 1944*

Some Local Education Authorities have been anxious to hand over a number of medical services to Regional Hospital Boards, even though they have concurrent powers for providing those services themselves. I have in mind particularly certain specialist services, such as ophthalmology and child guidance. This does not apply to all Regions, because I know that some authorities have continued to contribute to the salaries and have, therefore, had some say in the appointments made. I think this is a very desirable tendency, because it retains a degree of local democratic control.

### (iv) *Occupational Health*

This is a branch which has been largely neglected in the past by local authorities generally, but in some areas—particularly Glasgow—this is not the case. Actually, "school health" is part of "occupational health," because attendance at school is an occupation with its own hazards. The best use of manpower has to be considered, and whilst some of the largest concerns can afford to employ whole-time medical officers, who can specialise in their own particular industrial hazards, the preponderance of firms have to put up with a measure of part-time service from general practitioners or a flimsy sort of interest from local authorities. If we are to have a truly comprehensive national health service, I think it is wrong to ignore occupational hazards which arise during nearly one-third of a man's existence. I know the British Medical Association are considering the matter at the present time, and I think our Society should do everything in its power to promote experience and qualifications for medical officers and legislation for local authorities to have a more dominant part in the care of the worker in industry.

### (v) *The National Health Service Act, 1946*

As you are well aware, this Act operates by means of a tripartite organisation, namely, Regional Hospital Boards (assisted by Hospital Management Committees); Local Executive Councils; and Local Health Authorities. In my opinion, this is one of the main reasons why the Act is probably not working as well as it might. It is felt that if the three sections were "under one umbrella" there would be better liaison between them. There are many patients in hospital that should not be there, and many patients at home who should be in hospital. This would not be so likely to occur if the general practitioners worked part of their time in hospitals and could truly follow their cases either into hospital or back into their homes as required. A higher standard of medical practice would result from their

daily contacts with their colleagues at the central hospitals. This might be difficult to work in practice, unless there was a rota system in operation—yet it is difficult to visualise a rota working smoothly without a state salaried service, when the matter could be done relatively easily. At the inception of the National Health Service I felt that a state salaried service would have to come sooner or later, but I did not think it was likely at the earliest under twenty years. I am now doubtful whether we need to wait all that time for it to come into operation, for the following reasons:—

1. Many consultants are paid nine-and-a-half elevenths of a full-time salary today and it means a relatively short step for them to be full-time. Some, like psychiatrists, anaesthetists, and chest physicians, are already full-time officers.

2. When it comes to general practitioners it is true that they are paid on a *per capita* basis; but two steps have been taken which, in my opinion, seem to be in the direction of a whole-time salaried service: (a) the "incentive payments" for rural practitioners; and (b) the private arrangements made in many areas up and down the country for "group practice" today. From chats I have had with doctors I find that four, five or six men have grouped together and shared equally the *per capita* payments they receive. Some of them have told me that in spite of the increased demands of the public on their services, by grouping themselves together in this way they are able to have days and week-ends off duty, as well as to make arrangements for the work to be done during holidays and sickness, which makes life a little easier. I was speaking to one general practitioner recently who told me that he was now working with four others and they had a central "clinic" to which each of them had contributed £600, which enabled them to have consultations together for difficult cases, and for them to help one another in carrying out minor surgery, and providing them with tools to make more expert diagnoses.

The Act, however, has resulted in the planning of hospitals and specialist services over wider areas. Unquestionably there was a great deal of overlapping in the past which, in my opinion, resulted in a diminution of efficiency, and in some instances, possibly, in increased expenditure. This has not been due to the County or County Borough Councils, Boards of Management of voluntary hospitals, or to their respective officials, but rather to inherent defects in the system. For example, the Leicestershire County Council and Leicester City had, prior to 1948, two sanatoria within about five miles of one another; Nottinghamshire County Council and Nottingham City had, likewise, two sanatoria within about five miles of one another; the Derbyshire County Council and the Derby Borough Council had two mental hospitals within about three miles of one another; the Derbyshire Royal Infirmary and the Derby City Hospital are within about two or three miles of one another. If one first-rate hospital had been built in each of these instances, it would probably have served the purpose equally as well, and at the same time would have resulted in possibly more efficiency and certainly less expenditure. A wide view has to be taken in deciding on the need, location and size of hospitals, but surely the Ministry of Health, with their expert staff, could do this without the assistance of a body such as a regional hospital board, which, after all, has not been elected by the general public?

I would, however, mention three stories which bring out the value of medical administration:—

(a) A well-known consultant told me that he was not aware of the value of medical administration until he lost it under the National Health Service Act;

(b) A first-class business man who served on a Board of Management of a voluntary hospital told me that until they appointed a medical superintendent they had difficulty in evaluating the competing claims of the various specialities;

(c) A prominent American thought it was unfortunate that the Medical Officer of Health has been relegated to a relatively minor role, as his experience in medical administration would have been of inestimable value when launching a revolutionary but most desirable Act.

I have set out as follows some of the "pros and cons" of the Act:—

#### *Advantages:*

1. The State has rendered available treatment for all, based on medical rather than financial need.
2. The location and size of hospitals can be planned over wider areas.
3. Treatment in hospital is becoming more and more expensive—in fact, beyond the financial capacity of the former voluntary hospitals and even local authorities.
4. Specialists tend to reside in the major centres of population. There is now a better distribution of specialists to cover the whole country.
5. Local government boundaries are no longer of any significance regarding the admission of patients to hospitals.

#### *Disadvantages:*

1. The bodies set up to deal with Parts II and IV of the Act are not responsible for their activities directly to the electorate. If they were, it would be a corrective to the prodigious expenditure of public money. It is odd that local authorities set up for Part III of the Act should be responsible for collecting 50% of the money they spend, whereas regional hospital boards set up under Part II, and local executive councils under Part IV, are not.
  2. Outside the Local Authorities' sphere, medical administration is not considered of any importance, except at regional hospital board level.
  3. Regional Hospital Boards are too large and too remote from the day-to-day administration. Hospital Management Committees are too small: for example, twelve serve Derbyshire.
  4. Tripartite administration set up under the Act leads to misunderstanding, lack of co-ordination, and for the facilities provided not to be used to the best advantage. In fact, there are many patients in hospital that should not be there, and many patients at home who should be in hospital. The three components need integrating under "one umbrella."
- In order that local government should be able to tackle all the day-to-day administration required under the Act, however, the population to be served needs to be considered. I think a population of 500,000 to a million would be about the right size for dealing with all the health services. I think it was unfortunate that the Local Government Act, 1888, allowed county boroughs to be "carved out" of the geographical counties. I think the geographical county boundaries should be the unit of local government, with a two-tier system of government for certain services. (In the light of the powers given under any new legislation, it would be necessary to decide what should be deputed to each tier.) If the counties or county boroughs have not a population of at least 500,000, they should be merged with the adjacent authority or authorities. But I would emphasise that place of residence should not be of any significance regarding admission of a patient to hospital—the only criterion being that he should be admitted to the

most appropriate hospital having regard to his physical condition. If, however, this type of local government structure were formed, a medical administrator would be necessary to evaluate the claims of the various specialities which seem to be increasing in number as the years pass by.

Prof. C. E. A. Winslow, the Consultant in Public Health Administration to the World Health Organisation, has written a monograph on "The Cost of Sickness and the Price of Health," and I thought you would be interested in the following excerpt concerning the health services provided by some other nations in the world:—

"... the relations of the national health service to the local health services show the widest variations. At one extreme are countries where the national health administration provides all the health services which are available. At the opposite extreme is the U.S.A. where the national health administration has no powers of its own except in regard to overall quarantine regulations, otherwise serving merely as a stimulating agency to the State and local health departments. In Switzerland, also, the powers of the central health department are strictly limited by the Federal Constitution and each of the twenty-two cantons has its own separate health machinery. In other European countries the central administrator may deal directly with local health officers, as in Bulgaria. In the Netherlands, the national department supervises and, if necessary, supplements the provincial and municipal health services. In Norway, the central health administrator supervises the work of 380 health officers in provinces, districts and towns, who divide their time between public-health work and private practice. In some countries, as in Greece, the national health department provides direct local service by maintaining health centres, health institutes, and hospitals and clinics in local areas."

Any fair-minded person will say that the advantages brought about by the National Health Service Act far outweigh the disadvantages. The people of this country would never tolerate our going into reverse on the question, but that does not say that the Act cannot be improved, particularly administratively.

It has been said that the B.M.A. distrusted local government over appointments, because instances were known from time to time of "wire-pulling." The formation of regional hospital boards has not rectified the matter, because I believe in certain instances there have been cases of "wire-pulling." It is not the formation of regional hospital boards, or of county or county borough councils that is responsible for "wire-pulling," but rather the inherent defects in human nature!

Whilst the National Health Service Act has taken away from local authorities their duties in connection with hospitals, sanatoria, and maternity home provision, it gives opportunities of further expansion relating to the following services which were their responsibility to provide before July 5th, 1948:—

1. Maternity and Child Welfare;
2. Home Help Service;
3. Midwifery Service;
4. Health Visiting;
5. Care and After-Care of the tuberculous; and
6. Ascertainment and supervision of Mental Defectives in the community.

But the Act now also gives scope for the development by local authorities of further personal services, namely:—

- (a) Home Nursing Service;
- (b) Ambulance Service;
- (c) Care and After-Care for all types of illness;
- (d) The arrangements for the admission of patients to hospitals under the Lunacy and Mental Treatment Acts; and, after their discharge, their care in the community; and
- (e) The provision of Health Centres.

In order that a Medical Officer of Health should be successful, he should have a flexible mind so that it can be

adjusted to the varying duties and powers that legislation from time to time places on him, and should also be a student of his profession so that he is ever aware of the advances in medical knowledge. He should be able to handle staff and be prepared to deal fairly as a leader of a team with their problems, and last, but by no means least, he should be conscientious in the discharge of his duties.

It is a hundred and six years since the first M. O. H. was appointed, and, while Medical Officers of Health vary in ability, it can be fairly said that they have made a contribution to the substantial developments that have taken place in public health in this country.

## MATERNAL AND CHILD HEALTH IN SALFORD, 1928-52\*

By MARGARET SPROUL, M.B., D.P.H.,

Senior Medical Officer, Maternity and Child Welfare, City of Salford

In a few months I shall have reached my Silver Jubilee in Maternity and Child Welfare Work, and I thought that I would do a little reminiscing and talk to you of some of the changes and developments I have seen in a department such as we have in Salford.

### Vital Statistics

When I first came into the Health Department in Salford in 1928 the infant mortality rate was 106. The number of live births in that year was 3,993 and there were 431 infant deaths. The principal causes of death were then: respiratory diseases (22.8%), prematurity (20.9%), diarrhoea and enteritis (18.1%) and congenital debility and malformation—in this year there were 16 infant deaths from whooping cough and 12 from measles. As in other areas, our infant mortality rate has shown a more or less steady fall until it reached its lowest level last year—34—the first time it has been below 40, the number of live births in that year being 3,190 (800 less than in 1928) and the number of infant deaths 107—a considerable fall from that of 1928. The causes of the deaths are much the same as they were 25 years ago, except that prematurity is now the first principal cause and that deaths from respiratory diseases and gastro-enteritis numbered 11 and 13 respectively. The deaths from premature births are now 33. We had one death from whooping cough and one from measles.

### Neo-Natal Deaths

Our neo-natal mortality has not fallen so rapidly as one would wish. We still have too many premature babies, who die before they reach the age of one month in spite of all our efforts and special care. 69 of our infant deaths last year occurred in the first month of life.

### Stillbirths

Our stillbirth rate last year was 31. This is high as compared with some other areas and was disappointing, as in 1950 the figure was 23. But still these are an improvement on the 1928 figure, which was 49.

### Illegitimacy

Another figure which has shown some variation during the last 25 years is the illegitimate birth rate. In 1928 this was 3.9%. During the war it rose gradually, reaching 9% in 1945. It then gradually fell again to 5.1% in 1948, since when it has started to rise. Dr. Burn seems to think that Milk Bars may have something to do with this rise in the rate.

\* Presidential address to the North-Western M. & C.W. and S.H.S. Sub-Groups, Society of M.O.H.s, Manchester, October 24th, 1952.

### Maternal Deaths

The maternal mortality figures show the same trend as the infant deaths. In 1929 there were 17 maternal deaths in the city, five from puerperal sepsis. In 1951 there were three deaths, one of which was from sepsis. In 1949 and 1950 we had no maternal deaths. The Maternity and Child Welfare Department are entitled to claim a little share of the credit for these improved statistics, although we have still some way to go before our figures can compare with those of other countries and of some areas in this country. Our stillbirth rate last year, for example, shot up to 31. The rate for the previous year was 23. An analysis of the cases did not point to any one particular cause.

### Midwifery

As an Assistant Medical Officer, I did not have very much to do with midwives, but when I was promoted to the senior post I found that my duties included the supervision of midwives. There were 58 midwives then in independent practice in the city, and in 1930 they notified 2,332 births, which gave an average number of births per midwife of about 40. How they managed to make a living has always been a mystery to me. The standard charge for the services of a midwife in those days was £2 2s. 0d. for a primigravida and £1 15s. 0d. for a multipara, but some midwives charged less than that in order to undercut the other midwives. Usually the good midwives, of whom there were about 10 or a dozen, got most of the work, the other midwives doing a few cases per year. One of these midwives attended about 200 cases per year and although we watched her very carefully we could not say that her patients were neglected or that her work was not carried out in accordance with the rules of the Central Midwives Board.

The Midwives Act 1937 was to have a far-reaching effect on the practice of midwifery in this country. The Act gave Local Supervising Authorities the power to provide a service of domiciliary midwives adequate to the needs of the area, either by employing the midwives themselves, or through a voluntary agency such as the Queen's Institute. This followed the recommendations by Dame Janet Campbell in a report made about 1934.

In Salford it was decided that 22 midwives were sufficient for the needs of the area. Sixteen were appointed from the best midwives already practising in the city and six from outside the city. Most of the other midwives elected to surrender their certificates and claim compensation for their practices, and in about two years the whole of the domiciliary midwifery was being carried out by midwives employed by the Local Supervising Authority. There is no doubt in my mind that the standard of midwifery has improved considerably since midwives became employees of the local authority and members of the public health team working as practitioners of normal midwifery and calling the general practitioner to their aid when required, most of the ante-natal work being carried out in the local authority clinics.

When the birth rate began to rise after the end of the war, midwives were finding it difficult to cope with the increasing number of deliveries and to get in their ante-natal work. We then decided to establish midwives' ante-natal clinics. Each of these was attended by a group of midwives working in the same area so that not only did the midwives get to know each other's booked cases, but the mothers got to know the midwives who were likely to act as relief should their own midwives be off duty or sick when they started in labour. Mothers are sent from the midwife's clinic to the medical officer's clinic, information being exchanged between the midwife and the doctor. These clinics have been very successful and there are now ten midwives' sessions held weekly. At two centres a medical officer's and a

midwife's clinic run concurrently, these being most useful, as it often saves a mother making two journeys to a clinic and the midwife is able to consult the doctor immediately should she find any abnormality.

Since 1948, Salford midwives, like others, have had their difficulties and anxieties with the health service. They felt at first that they were being pushed out and relegated to the status of maternity nurses and that the general practitioner obstetrician was going to steal the picture, but time has proved that this is not so. A few of the G.P.O.s are taking their duties seriously and are not content to do only two ante-natal examinations and one post-natal examination and to leave the rest to the midwife. But the majority are quite content to do the minimum to earn their fee. Some told their patients that there was no need for them to attend the local authority clinic and there was a slight falling off in attendance there.

Dr. Burn offered the facilities available at our ante-natal clinics to any of the G.P.O.s who cared to see their booked cases there. Only one in Salford availed himself of this offer and he has been coming regularly to the midwife's session at one of the clinics for three years. Recently one G.P.O. started to hold a weekly clinic at his surgery and arrangements have been made for the midwives who are booked for his cases to attend his clinic in rotation. A fortnight ago the same arrangement has been made with another G.P.O.

Soon after the appointed day one G.P. complained that he was not being sent for by the midwife when his patients started in labour. A few days later another said would I please instruct the midwives not to call him when his patients went into labour unless he was required.

#### *Health Visiting*

In 1928 the establishment of health visitors in Salford was 16, including the superintendent, among them some appointed to the staff in 1915 or just after—it was these pioneer health visitors who paved the way and made it easier for their successors to enter the homes of the people. Most of them possessed some nursing qualification, some were trained in general nursing, some were fever trained, and some had a midwifery qualification in addition to their other training.

By 1928 health visiting had become well established in the city and the mothers took the visit of the "Baby Woman" as a matter of course. These health visitors were not so highly qualified as their successors of today, but as most of them had been on the district for some years they knew their families and were looked upon by the mothers they visited as friends to whom they could turn for advice not only about their children but all their domestic troubles.

The health visitors of today do not settle down and stay in one area for several years as their successors did. Changes of staff are very frequent and we are finding greater difficulty in replacing those who leave, with the result that our staff is never stable. I consider that it takes a health visitor nearly five years really to know her district. The frequent changes in staff are bad for the work, which in Salford is very hard. We have so many problem families, housing conditions are bad in many districts, and there is very little to lighten the burden of the health visitor in a city like Salford, and one cannot blame her for wanting to move to more pleasant surroundings in which to work and live. The time has come when local authorities in the industrial areas should be allowed to offer some inducement in the form of extra salary to attract health visitors to their areas.

Owing to the difficulty of getting health visitors during the war, Dr. Burn introduced to the service the assistant health nurse—we now call her the clinic nurse—whose

function was to assist the health visitor and to relieve her of duties which could quite well be performed by less qualified staff. These clinic nurses are trained nurses, state registered, and may or may not be state certified midwives. They attend the ante-natal and child welfare clinics, carrying out immunisations in the clinics or in the homes; they take specimens of blood, examine urine, etc. They have proved to be most useful members of the staff. From time to time the Ministry of Health has granted us a dispensation to use some of these clinic nurses for health visiting duties in the homes and in the clinics. Before they were allowed to visit the homes they were given a short training by the superintendent or her deputy. These appointments are only temporary, until we again have a full H.V. staff.

In 1943 all our health visitors have been doing combined work—health visiting, school nursing and tuberculosis visiting—the idea, of course, being that there should be only one visitor to the home and that the health visitor should be able to follow the child from birth till the time he leaves school. This looks all right in theory, but does not really work out in practice. For it to do so you must first of all have a stable health visiting staff, child welfare work and school work must be so arranged that one does not dominate to the detriment of the other. The sort of thing that so frequently happens is that a health visitor has a certain district in which she does child welfare, school nursing and tuberculosis visiting. She does her welfare centre on a certain day in the week. The School Medical Department decides that a medical inspection must be done in the schools in her area. All her other work has to be dropped for the time being until the inspection is over. This makes take days or even weeks and in the meantime her work is at a standstill. This will continue to happen until we can make the Child Welfare and School Medical Services one Child Health Service under one single administrator.

In 1944 an assisted training scheme for health visitors was introduced. With this scheme we can now take on eight student health visitors yearly. They go to one of the training centres for six months, during which time they are paid  $\frac{2}{3}$  of the salary of health visitors, have all class fees and examination fees paid. After they have completed their training they work in the department for a further twelve months. At the end of this period the Corporation has an option on their services for another six months. We have found this a most useful method of recruiting staff, for not only do we have their services for 18 months after training is completed, but many of them apply to be taken on the permanent staff.

The increase in the scope of the health visitor's duties under the National Health Services Act has necessitated a considerable increase in the establishment. Personally, I think we are asking the health visitors to do too much. Her case load of pre-school and school children is too high, she is expected to give advice on the care of the sick and the aged, to visit the tubercular, to attend M. & C.W. clinics, school clinics and specialist clinics, to teach in clinics and schools, to run Mothers' Clubs, etc., etc. She never gets a job done completely, she is always being called away to do something else. Is it any wonder that she gets "fed-up" and frustrated, and drift away to other branches of nursing and to areas where not so much is expected of her.

The latest development in the health visiting service is the appointment of specialist health visitors for care of the aged, for the neglected child, for liaison with the hospital. These are supposed to specialise in one particular branch of their work and to devote most of their time to it. The other H.V.s consult them when they have difficulties.

### Maternity and Welfare Centres

When I first came into public health work all of the M. & C.W. clinics were held in adapted premises and how bad some of them were—in Sunday School Rooms and church halls entirely unsuitable for the purpose. The whole health department was housed in a block of houses and shops and still is. At one of our centres the premises—a church hall—were shared with the School Medical Department, and as school medical sessions and M. & C.W. sessions were held at the same time you can imagine what it was like. The expectant mothers had to undress in a screened off corner of the common waiting room—there was no other place.

In those early years we seemed to get quite frequent visits from Ministry of Health Inspectors who always reported adversely on our clinic premises, but nothing was done about them for years afterwards. Since those days we have gradually acquired premises of our own, which, although they have not been built as such, have, with suitable alterations and adaptations, made quite satisfactory centres.

In addition to our clinics and centres, we had until 1936 a small maternity home with 11 maternity beds and 10 cots for cases of rickets and six cots for sick babies. One of the M. & C.W. medical officers was resident and in charge of this home and also did part-time duty in the clinics. Only normal maternity work was done here, all abnormal cases going to Hope Hospital. The children's beds were most useful. Children seen at the centres could be admitted and cared for by our own staff, which consisted of old medical officers, including the one who was in charge of the home. The others relieved her on her week-ends off. This gave the opportunity of doing some practical midwifery as well as the ante-natal work at the clinics. But, alas! a medical officer from the Ministry came to see us and in his report recommended that all the midwifery should be concentrated at Hope Hospital and the home closed. Some members of the Council were only too glad to take the advice, as the home was very expensive to run, as all such small homes are, and to the great regret of the staff and the mothers it was closed in 1936.

The average attendance at most of our child welfare sessions was 80. In some centres an attendance of 100 and over was quite a common thing. The Medical Officer usually saw 30 to 40 children in a session and as there were so many children with defects, routine examinations were almost an impossibility. There was much poverty in Salford in those days and there were many children suffering from malnutrition. The fact that the Corporation in 1930 was spending £5,000 per annum on free milk for necessitous cases among the expectant and nursing mothers and young children of the city will give you an idea of what conditions were like.

Rickets, of course, was very common and we saw all forms of it from the mild to the more severe with deformities which we now see only in pictures in text books. Respiratory infections also were very common and still are. The mother would often say "he was born with it, Doctor," of a child with bronchitis.

Feeding difficulties, of course, we had by the score. Babies in those days were fed strictly by the clock and no night feeding was allowed. Mixed feeding (diet?) was not introduced until the 8th or 9th month. Now, of course, the teaching is feed "on demand" and give a night feed, if necessary, and introduce mixed feeding at 3-4 months. We still have the same difficulties about breast feeding as we had them. I reckon that only about 30% of mothers successfully breast-feed their babies for six months.

To try to overcome some of the difficulties of breast feeding we met with in the clinics, a Breast Feeding Clinic was started at Hope Hospital in 1943. This proved to be a most useful addition to our activities. One just has not the time at a long welfare session to give the attention required by some of the mothers having breast feeding difficulties. The mothers referred to the clinic spent the greater part of the day there arriving in time for the 10 a.m. feed in the morning and leaving between 4 and 5 in the afternoon, so that at least two feeds could be supervised. It would have been better, of course, if we had had some residential accommodation for the mothers, but this was just not available, but even with its limitations I think we can claim that the clinic was a success and many mothers benefited from the help and advice they received. Unfortunately, the clinic had to be discontinued after July, 1948, as we were not allowed to carry on a public health service on hospital premises. We are hoping, however, to start another clinic in our own premises very soon.

In the meantime, we have appointed a Breast-Feeding Sister who comes to the clinics and visits the mothers with feeding difficulties in their own homes.

At our ante-natal clinics specimens of blood have been taken from every mother attending for routine W.R.'s since 1943 and for Hb. estimations, and since 1947 for Rhesus Factor. We are fortunate in Salford in having the Pathologist's Laboratory on the Health Department premises. The specimen is collected in one syringe, and the specimen for W.R. and Rhesus is put into one tube, and for the Hb. estimations into a tube containing Potassium Oxalate. These are sent to the Laboratory. A Kahn test and a test for Rhesus factor is carried out. If the Kahn test is positive then a W.R. test is done. If this is positive a repeat test (W.R.) is done and if this is positive then the mother is sent to V.D. Clinic for treatment. A preliminary test for the Rhesus factor is taken at the Salford Laboratory and if the result is negative another specimen is taken from the mother and sent to the National Blood Transfusion Centre at Roby Street (Dr. Stratton, who gives a final report as to whether the mother is Rh. negative or not). All Rh. negative mothers have a repeat test done at the 36th week if they have not already been found to have antibodies.

Last year out of the 1,127 blood specimens taken for the presence of syphilis only four were found to be positive (.035%) 17% of the mothers who attended the Ante-Natal Clinics last year were found to be Rhesus Negative. Eight mothers were found to have Rhesus Antibodies. All were sent to Hospital for delivery, six were subsequently delivered of live infants, who were treated either by replacement or straight transfusion and have done well. The seventh one had a macerated premature stillbirth and the eighth had a live birth, but the infant survived only a few minutes.

### Voluntary Workers

Before I close I should like to say something about the voluntary work which was carried out in Salford.

The first Health Visitor was appointed in Salford in 1862 by a voluntary association interested in child welfare, called the Ladies Public Health Society. When I joined the Health Service this Society was still flourishing. Their activities included the provision of dinners for expectant and nursing mothers, the running of sewing and knitting classes at the welfare centres. They did not do any of the weighing of the babies or selling of food, as is still done by voluntary workers in other areas, and which I believe they had also done in Salford when welfare clinics were first started.

Dinners at a cheap rate (the mothers paid 2d. only) were

provided at three of the centres five days per week, and when a mother was confined the dinner was sent home for her. This service was run entirely by the voluntary workers, with the help of a grant to cover the cost of food, from the City Council. Thirty to forty dinners were served at each centre per day. The service was continued until after the end of the War, but with full employment and family allowances there did not seem to be the same need for it as there was between the two wars, and a service which had been in existence in Salford for over 40 years came to an end.

#### *Toddler Clinics*

Another activity added to our list recently is routine examinations of the one to fives. This, of course, is not a new idea, but we have not been able to do it until recently because of the shortage of staff. Invitations to attend for medical examinations are sent out on or about the child's birthday. About half the number of children invited turn up. The response is much more than we expected. That they are worth while is seen from the figures. Out of 348 children examined, 170 defects were found. Only 158 of the children seen were taking the vitamin supplement distributed by the Ministry of Food.

#### *Liaison with the Hospital*

There has always been very close co-operation between the Maternity and Child Welfare Department and Hope Hospital in Salford, and this has continued. Dr. Burn, soon after he came to Salford, arranged for the late Dr. Catherine Chisholme to hold a Consultant Child Welfare Clinic at one of our Centres. The Medical Officer referred cases of special difficulty to Dr. Chisholme at the clinic. The consultant clinic is now carried on by Dr. R. I. Mackay, the paediatrician at Hope Hospital. Two of our officers attend at the hospital regularly and accompany Dr. Mackay on his ward rounds and at his Out Patient Clinic.

The special health visitor for liaison with the hospital attends at the hospital twice weekly. She is able to give the staff of the hospital information about a child's home background, etc., and also carry back information from the hospital to her colleagues at the health department.

In addition to these personal contacts, a letter is sent direct to me whenever a child is discharged from the hospital, giving details of diagnosis and treatment. These are most useful for both Medical and Health Visiting Staff.

### THE FUTURE OF CHILD WELFARE CLINICS\*

By ELENORA SIMPSON, M.B., CH.B.

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In the past six months there seems to have been a crescendo of articles and discussions on the Maternity and Child Welfare Services, and I feel rather diffident about inflicting the subject on you again. But one great advantage in speaking to you is that we are all public health officers and therefore any views are, so to speak, within the family circle.

Many different ideas are being put forward, and there appears to be a strong undercurrent of feeling that child welfare clinics have had their day, and that more preventive work should be done by hospitals and general practitioners. The reasons advanced for these views are many and various—redundancy, overlapping, expense, etc.

What I want to do this evening is to try and answer some of the criticisms, to emphasise some special aspects of child

welfare work, and to advance the view that sooner or later the main emphasis in medicine must pass to the preventive aspect; and that attendances at the child welfare clinics of today are the firmly established forerunner, in fact the foundation, of a comprehensive scheme for regular medical examination throughout life.

Having placed my cards on the table, may I deal first with some of the criticisms of the present service?

Reduction of infant mortality rate having been achieved, there is a question as to the continued need for the supervision of young children. The idea seems to be that because infant mortality, particularly in the period from one to twelve months, has fallen to its present low level, we can abandon the clinics and rely on the hospitals, general practitioners and health visitors for preventive work. But while the fight against deaths from infantile diarrhoea is won, a major cause of early death today is found in respiratory diseases. We know that the incidence and mortality of these disorders is reduced by breast-feeding. I believe that clinic advice, test-feeding, example, etc., are powerful adjuncts to the health visitor's work in the home.

Again, for example, we hear sweeping statements that rickets nowadays can only be learnt about in text-books as it is never seen. This is in some measure true. The propaganda and education on the need for vitamin A and D preparations now prevents many children from developing rickets. We see any early cases at the centres and so prevent them from developing. I am sure that every clinic doctor in an industrial area will agree with me that it is this early diagnosis and use of UVR and orthopaedic measures which prevent frank rickets, some return of which would occur without such measures.

Again, a point was made by Dr. F. J. W. Miller of Newcastle in *The Medical Officer* (6th Dec., 1952) that only a proportion of mothers bring their children regularly to the clinic. This is perfectly true, but are we to abandon the service because only one-third of babies are brought with any regularity? The attendances have grown with the years and, in my experience at any rate, the introduction of the National Health Service has made no difference in this—80% of the children born in Halifax are still brought to the centres at the very least once, and half these children attend until after they can walk. A need is clearly felt and met. It would be a serious matter to scrap patiently built-up habits and organisation without the most careful thought.

Then there have been references to the expense of the Child Welfare Services. No objection could be more extravagantly unreasonable. The whole preventive service only costs 7% (1949/50) of the total National Health Service expenditure. Dr. Galloway, Medical Officer of Health, in his annual report for Wolverhampton, quotes the figure of £5 9s. 0d. per head for hospital and specialist service throughout England and Wales, (1951/1952), and 8/6 per head in Wolverhampton for the care of mothers and young children, health visiting, vaccination and immunisation. I do not know if Wolverhampton is especially economical but even if this figure is exceeded in other boroughs, it will still remain a matter of shillings spent on prevention, and pounds on cure.

Sir James Stirling Ross in his recent authoritative book reviewing the progress of the National Health Service reminds us that finance and policy are inexorably one and he says "The cheapest and best of health measures is prevention, whether absolute prevention or treatment in the early stages."

One frequently sees statements that only the general practitioner know the whole family, its home and background. But does he? As a matter of interest, for two

\* Paper given to the Yorkshire Branch, Society of M.O.H., Leeds, April 24th, 1953.

weeks recently I asked the mother of each toddler I saw, how often the family doctor had seen the child. There was an average of three cases per clinic of children between one and two years who had never been seen by the family doctor at all, and in more than half the other children, he had seen the child only once since birth—the curative need was met, but not the preventive.

A point of practical and far-reaching importance is that the preventive approach demands a quite different technique and tempo from that to which the general practitioner is normally accustomed. I cannot by any stretch of imagination see the busy general practitioner undertaking at all readily the laborious task of enquiry and instruction required by the purely preventive approach.

It does not seem to be recognised outside our service that mother craft teaching requires a special technique. There is a marked difference between giving advice in a case of illness and the attempted education of a mother whose child appears perfectly well. In treatment for illness, hospital staffs and general practitioners are dogmatic, and the patient usually accepts this attitude with thankful meekness. But if you want to prevent ill-health in mind or body, you have not the firm foundation of a patient's illness on which, so to speak, to stand and shoot. At the most, you have the mother's confidence and relying on that you must instil a desire for positive health so that she herself takes the first step along the road you mildly suggest is the right one. It is not difficult to appreciate that this must take more time and patience than is usually possible in hospitals and surgeries. One of the hardest lessons a child welfare officer or health visitor has to learn is that the authority wielded in hospital cannot be employed with mothers.

This leads me to say that I believe one of the reasons for the criticisms of the centres is lack of knowledge and understanding of the work done there, and therefore serious failure to grasp its importance in the effort of today and relationships to other branches of medicine and especially to future. I think we have ourselves to blame for some of the ignorance about our work, because until recently very little was published, at least in the non-specialised medical journals. We have great opportunity for surveys of healthy children which would add to knowledge, for example, on breast-feeding and its influence on prevention of disease, on behaviour problems, on juvenile delinquency, fields of prevention which would pay very big dividends, but about which we have only impressions which do not carry the weight of facts. The application of the recently developed science of social statistics has surely scope here.

Thirty years of child welfare clinics has done much to educate the mother in the idea that clinics are there to help to keep her baby healthy. We distribute foods, we also give some minor medical attention, but our principal, and in the long run really important, function is two-fold: (1) education in health measures and (2) the diagnosis of the early signs of disease. But these important functions are not, I think, fully understood by our medical colleagues outside the public health service. Is there not a tendency for them to think of the advice at clinics as being confined to napkin rashes, clothing and weaning—matters which could be and are dealt with by the health visitor?

I began, at any rate, by saying how the present unfortunate trend of ideas seems to me to be that child welfare clinics should cease either because they have fulfilled their function of reducing infant mortality or because they do not meet the needs of today. But if they cease, the present generation of young mothers would be deprived of a major source of their education in mothercraft and much propaganda for immunisation and vaccination, especially by

posters, example and group teaching. I am not belittling the home visitation by health visitors. I think it is of great importance, and I wish these highly trained nurses got better recognition and were more used by general practitioners.

And what about preventive work in mental health? I have seen little mention of this, but every child welfare medical officer knows how much time is spent on behaviour problems, and as they are so often caused by marital discord one is frequently led on to marriage guidance. I think it is in the privacy of the medical officer's clinic consulting room that the real causes of many difficulties—whether mental or physical—in bringing up children emerge. Tribute has been paid to the early diagnosis of physical disease at clinics, but less than lip-service is paid to the attempts made to prevent anti-social behaviour in later life. This is an aspect of preventive work which I believe will have ever greater attention.

Leaving the question of education in health and coming to what I gave as the second essential function of the clinics, namely that of diagnosis of the early signs of disease, first I think that far too little emphasis has been placed on the fact that child welfare officers have an unrivalled training in what constitutes normal health and progress. The procession of hundreds of children seen at clinics gives us a yardstick of the range of normality in the case of early life which, I submit, is rarely gained by the general practitioner always preoccupied with the claims of the sick. I believe this yardstick gives us an intuition—a flying start—in diagnosing the first departure from normal which indicates that something is wrong. For example, my colleague and I recently had four cases of primary tuberculous complex in as many weeks.

There has been much talk of child welfare medical officers doing some hospital work but very little about house physicians attending child welfare clinics. I once suggested to a paediatrician that his housemen might come to the child welfare centre, but he said they would find it boring as they were only interested in illness. This experience incidentally does not support the idea that the hospital staff would take kindly to preventive work.

I know that advocates of a combined preventive-curative service point to the need for the better education of the medical student in positive health and social medicine, but the curriculum is already so long that it is difficult to produce a space for an adequate training on the subject.

I believe that what we need is not the abandonment of child welfare clinics, but above all things a much better co-operation between the three essential branches of the Health Service, i.e., the clinics and their related agencies, including most importantly the health visitor, the general practitioner, and the hospital service. But I think that we will only get this when the clinic service is seen to be the chief existing embodiment of the positive health idea in the community, and the forerunner of future health measures amongst the adult population. The National Health Service has removed one former annoyance to general practitioners associated with the idea that the child welfare clinics deprived them of fees. This may not have been a serious reason why co-operation was poor in the past, but at any rate co-operation is the over-riding essential for further progress. My experience is that there is not enough exchange of information between the child welfare service and the general practitioner. And in some instances where the general practitioner refers cases to the clinics for advice I suspect it is to get rid of a talkative mother.

To come to my principal point and to gather up what I

have already said, I believe attendance at the positive health centres already established in our local authority in child welfare clinics for children up to five years, should be continued throughout life, so that regular medical examinations become a habit, in just the same way that those who took good care of their teeth visited the dentist at intervals of say six months whether they had toothache or not. The ultimate aim of the National Health Service can surely be nothing less than such periodic examinations. This is not a new idea. I believe regular medical examination is a condition of lower premiums in certain insurance companies in the United States—a condition based on sound business acumen in which we seem to be singularly lacking in the economies of the National Health Service. The same plan is followed in our universities and some hospitals where medical students and nurses are examined and screened at regular intervals. The service of mass radiography is being increasingly patronised by the general public. Recent correspondence in the *British Medical Journal* has shown that there is even now some degree of popular demand for "regular overhauls" though some G.P.s don't seem to like the idea at all.

The late Sir James Mackenzie had the idea of regular examinations when he established the Institute of Clinical Research in St. Andrews in 1920. He believed that a disease which might not show itself until adult life had its beginnings in childhood, so he started what was the prototype of a health centre—one building housing X-ray, laboratory facilities, consulting rooms for general practitioners, waiting room, accommodation for clerical and caretaker staff and a special children's department to which children came regularly by appointment. He chose St. Andrews as being sufficiently small to be manageable—a university town with no industry except hotels, and incidentally (and perhaps not quite incidentally) a delightful golfing resort with a sunny dry climate.

I had the privilege of being in charge of this children's department and the laboratory, and also the town child welfare centre, for ten years from 1936. The children's records from the child welfare centre were transferred to the Institute when the child was two years old, and thereafter the children were seen three monthly until five years of age and yearly until they started work and came under the National Health Insurance. The records had added to them the notes of the School Medical Officer and any specialist service, and also the personal notes of the family doctor of any illness he treated. There was a weekly staff meeting attended by the general practitioners when there was a discussion of cases. In this way very complete records were built up, being continuous in some instances for more than twenty years, and it is believed unique anywhere in the world. But alas! with war conditions and the absence of Sir James' dynamic personality, which had welded the different departments together and maintained the principal object, the Institute closed in 1946.

Actually, and apart from the factor of leadership, which is always important, the moral of this story is the amount of good will and co-operation the health centres need if they are to run effectively—co-operation more than anything else is the key to progress; absence of it is fatal.

What then is the aim for the future? In the 1938 revised proposals for a General Medical Service for the nation published by the B.M.A. it was stated as a first principle "That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than the relief of sickness." A positive conception of health is better than that of the negative idea of prevention of disease. The latter tends to look for

the signs of particular disorders, the former is on the lookout for every departure from the normal, whether it fits into known categories of disease or not. Hence discovery and progress!

It has been pointed out by Dr. Ffrangcon Roberts and others that our medical services are getting into very deep waters, for statistically the illness rate is actually increasing—we live longer and suffer more therefore as a nation from chronic and degenerative illnesses. Acute illnesses get in the nature of things priority of attention, and we therefore tend to move even further away from the preventive approach which is the answer to this chronic trend. We must try to prevent coronary thrombosis, lung cancer, duodenal ulcer, nervous disorder, and even to arrest degenerative process so that old people may live more useful lives. It will be realised that a large part of the medicine of the future will, as preventative be educative in character. We must indeed prepare ourselves for a great change from the dramatic conception of medicine as the scene of frequent interventions by doctor and surgeon at the call of pain, injury and disease, to that of a quieter and less sensational process of regular examination and persistent education. Precept will in large measure take the place of physic in the medicine of tomorrow, though this is not to rule out improved physical methods of treatment, not to speak of new medicaments.

To sum up, and with all respect to eminent authorities who think otherwise, I do not believe that it is possible for the preventive work of the present child welfare clinics to be done either by general practitioners or hospital paediatricians. First, because the claims of curative medicine are so urgent the preventive side will inevitably be swallowed up; secondly, because education in positive health and requires a special technique; thirdly, because I would most diffidently advance this view, those whose skill and interest it is to treat fully established illness are not always trained to recognise the earliest symptoms of disease by having seen hundreds of normal children.

I believe it is absolutely vital to retain the three distinct divisions of the National Health Service following the individual from the cradle to the grave—preventive, general practitioner, and hospital. These branches fail in their responsibility to the ultimate aims of medicine if they work in water-tight compartments. They succeed as they exchange information with each other so that the patient can obtain the best possible advice for his health.

#### SLUM CLEARANCE IN LIVERPOOL \*

By R. BRADBURY, B.A. (HONS. ARCH.), M.Sc., PH.D.,  
F.R.I.B.A., A.M.T.P.I.,

*City Architect and Director of Housing, Liverpool*

I am very pleased that Dr. Semple suggested that I should make a contribution to the afternoon's proceedings, for many reasons which I shall try to bring out.

The problem of furthering social improvement with the limited resources we have available is rather like a small man who is called upon to move a very large grand piano, single handed, from one corner of a large room to another. First, he must pull a little at one corner of the roughly triangular shape which a grand piano takes, then he must pull at another corner. He must ease the third leg over the edge of the carpet and gradually, by the aid of a good deal of sweat and physical effort, plus the application of sound common sense in the use of his limited physical force, it is surprising how well he will succeed and what progress he will make in his apparently hopeless job.

If we label the three corners of the grand piano Health, Education and Housing we shall, I think, have a very clear

\* Address to the North-Western Branch, Society of M.O.H., Liverpool, March 13th, 1953.

picture of the problem of social betterment. For all of these three important lines of attack on the problem of improving living conditions for all are indissolubly bound together by the iron frame of hard fact and the more intangible but nevertheless equally important and strong wood fibres of policy and psychological matters. In other words, the problem of social betterment is a team job and it is ever so much easier if there are three symbolic little men to exert their pushes and pulls on each corner.

Fortunately, in Liverpool we have had a big man handling the health corner, but I will speak more about him anon. What I want to do just at the moment is to deal with the general position. Unless people are properly educated they cannot fully use the services and facilities provided for them by the health and housing organisations. Unless people are healthy they cannot use the homes which are provided for them properly and fully enjoy the fruits of the education which they have been given. Unless the health organisation is efficient the educational and housing efforts will not be of much avail. It is in this sense of unity of purpose and effort that I want to talk about the great contribution which Prof. Frazer has made to the great work—and it is a great work—which my department, under my distinguished predecessor, Sir Lancelot Keay, has done in the field of housing for Liverpool and which I and my colleagues are now attempting to carry forward. We have relied, and still rely, for much of the success of our efforts upon the work of the Public Health Department and the person in charge of it.

May I, just for a moment, analyse the general line of attack on the housing problem which faces this city, as indeed it faces practically every other city, town and village of our country at the present time, and which is likely to be a continuing problem, unfortunately, over many future years. The attack upon the housing problem is two pronged. First, there is the building of vast numbers of new dwellings of all kinds on virgin land in the suburbs and on the periphery of the city. Although under present circumstances this is difficult enough, it is, relatively speaking, the easier aspect of our task. It is purely a legal problem so far as the acquisition of the land is concerned and thereafter an architectural and building problem in which the health aspects are relatively easily dealt with. Provided the new estates are laid out on proper planning lines and the buildings themselves comply with the presently accepted standards of habitability and efficiency, this attack is not one in which the Public Health Department is directly concerned, but the building of new houses on virgin land is only one prong of the attack. The second prong consists in the much more difficult problem of slum clearance and the resulting central area redevelopment. It is in this aspect of the attack on the housing problem that the Medical Officer of Health for the area and the department which he leads have such a vital part to play in the success of the housing drive. Indeed, there could be no progress in slum clearance and central area redevelopment unless the medical officer took the initiative and used intelligently his statutory and other powers dealing with the obsolete and insanitary dwellings without whose demolition no progress at all could be made in making over the older areas of our cities and towns anew. Prof. Frazer has a very proud record of achievements in this City of Liverpool and the part which he has played in making possible the building of the vast blocks of flats in Liverpool, known all over the world where housing is studied, must surely be regarded as one of his greatest achievements during his period as Medical Officer of Health of this great city. With my predecessor he worked in the closest harmony, and I should like to place on record my grateful thanks for the continuation, with me, of the same happy and co-operative relationship, for, during the four and a half years I have been City Architect and Director of Housing here, we have not only continued the "recipe as before," but we have jointly laid plans which augur well for the future of slum clearance and redevelopment in our central areas.

Up to the outbreak of war Prof. Frazer had represented for demolition nearly 13,000 dwellings of which practically 5,000 had been demolished prior to the war and replaced by flats and cottages. There would have been no St. Andrew's Gardens, Gerard Gardens, Caryl Gardens and many other great blocks of flats which have provided happy homes for Liverpool families for so many years now unless Dr. Frazer had worked conscientiously in his health corner to further the progress of the housing corner.

Mr. Barnes, in his book on the slums, has this to say: "In the Judgment Book it is said that our merits and demerits are to be found. I can imagine no more satisfactory record than that of those who, if they have not dreamed of a new heaven, have at least attempted to create a new earth. To be written down as one who loved his fellow men sufficiently to care how they were housed and with what environment of health surrounded, should be enough for most, and happily will be for many." Prof. Frazer must, I know, have a great feeling of satisfaction when he looks back, as I hope he will continue to do for many years to come, upon the housing fruits which have resulted from his common sense and realistic use of the powers in connection with housing with which he was entrusted during his years of office as Medical Officer of Health for this city. He has been, as it were, a John the Baptist of Housing in Liverpool, the voice crying in the wilderness of Slumdon, not merely crying but acting too, making the way clear for the old to be pulled down and to be replaced by the new.

Although, officially, slum clearance has not been proceeded with since the end of the war, Prof. Frazer and my other colleagues and I realised that much preliminary work could be done to enable a start to be made as soon as conditions permitted. We have jointly not only explained to our committees the need for the reopening of the slum clearance drive but we have been working quietly together planning a campaign for the last two years and the officials of our two departments have co-operated very closely on the matter. In December, 1951, I was able to persuade the Council to take practical steps by obtaining authority to set aside for families from clearance areas 90% of the new flats being completed in the inner wards of the city as well as obtaining permission to house up to 300 additional families on suburban estates despite the competition from applications on the general register. This will enable about 1,000 families to be cleared annually from the central areas and make possible the demolition of about 700 slum dwellings per year. Already we have housed over 800 families from clearance areas. Working closely with us, Prof. Frazer has represented, and his department is continuing to represent, month by month, pockets of obsolete and insanitary dwellings, the sites of which the Housing Committee is purchasing compulsorily, thus making it possible for my department to plan ahead a definite slum clearance programme. In September last year the City Council approved a report for the redevelopment of eight central housing areas, comprising an appreciable part of the inner wards and covering the erection of just over 4,750 dwellings. The estimated cost of these on the basis of current prices, taking into account not only the building costs but the acquisition of sites, is likely to total somewhere in the region of £10,000,000. Already contracts for many hundreds of central area flats have been let and they are building now, whilst others are at the drawing-board stage and will follow on. Admittedly, this is not nearly enough when the overall problem of slum clearance is considered but it is nevertheless a substantial restart and, moreover, one which places the City of Liverpool well in the post-war forefront on central area development and ahead, also, of the Government instructions and circulars. To be in this position is in no small measure due to the personal efforts of Prof. Frazer. He leaves Liverpool with a great record of housing achievement behind him, to which he has personally made a very great contribution, but perhaps, more important still, he leaves Dr. Semple to take over at a time when there is already much in the

"kitty" and with an established technique for continuing and expanding the process.

May I just finish on a personal note? Prof. Frazer has been kindness itself to me as a colleague. He is a man for whose integrity, knowledge and personality I have the highest respect. I am proud to have had the opportunity of working with him during the last four and a half years and it is with the utmost sincerity that I wish him the very best of good things in his well-earned retirement.

#### DISCUSSION

The President (Dr. K. K. Wood) asked Dr. Bradbury if he had any suggestions to offer regarding the keeping of a green belt round a small authority.

Prof. Frazer thought it was a good thing to have a young, fresh architect from time to time and he had been fortunate in having the opportunity of co-operating with such a man as Dr. Bradbury. When he took up duties in Liverpool in 1931 he was faced with the two problems of hospital re-organisation and slum clearance. Up to 1939 he inspected personally about 14,000 houses and had hoped he would have the honour of completing slum clearance in Liverpool, a privilege which had been denied him by the outbreak of war. He had had tremendous assistance from Dr. Bradbury in the post-war years, particularly on the subject of the accommodation of old people, and a new home was to be opened in Liverpool in June.

Dr. Berry suggested that the problem in a small authority such as Wallasey was different and really difficult inasmuch as so many of the cleared sites were too small to permit any large-scale use of them. Dr. Metcalfe Brown thought that despite the difficulties of land, labour and the like, housing was a fundamental problem and must be cleaned up. He mentioned specifically the problem of trying to do something about houses that were falling down, a problem that was giving anxiety in Manchester, and referred to the difficulties of sub-standard families and sub-standard houses.

Dr. Burnett developed this point by referring to the pre-war conditions when an abundance of housing enabled families on the upgrade to move to better housing, whilst those on the downgrade moved into poorer property, whereas to-day, with house-room being in such short supply, the sub-standard families tended to be evicted and had no alternative accommodation to turn to other than temporary accommodation provided under the welfare services. He considered that it was impossible to apply effective measures of rehabilitation to problem families when these families so frequently lacked a home of their own and felt that it was essential that local authorities should have an adequate supply at the present time of sub-standard houses that could be utilised for the difficult cases that were unsuited to the modern council house. He enquired from Dr. Bradbury how Liverpool tackled such a problem.

In reply, Dr. Bradbury suggested that a green belt should never be allowed to become a green corset and that the conflict between agriculture and housing ought to be resolved quickly. He agreed with Dr. Berry that there were difficulties about the development of very small cleared sites, but nevertheless in Liverpool they had adopted the policy of infilling with wide fronted narrow depth cottages, often without a garden, and there was a persistent demand for this accommodation. In Liverpool there were, of course, many problem families and this was a very difficult issue, but fortunately the Liverpool Corporation possessed some 2,700 old properties built before the first world war and these were used for this purpose, though even this was not nearly enough to meet the city's difficulties.

Dr. Gawne, in felicitous vein, expressed on behalf of the meeting his very great pleasure at being able to thank Dr. Bradbury for the very stimulating address to which we had just listened. He knew personally Dr. Bradbury's sterling qualities and was pleased to say that there was the happiest and closest liaison between the speaker and himself over the problems of overspill housing development in the adjacent county areas. He was happy indeed, as a Liverpool man, to congratulate Dr. Bradbury on the work he was doing for that city.

The appointments of Queen's Honorary Physicians recently approved by Her Majesty include those of three Fellows of the Society, namely, Dr. G. E. Godber, Deputy Chief Medical Officer, Ministry of Health; Dr. E. K. Macdonald, Medical Officer of Health and School Medical Officer, City of Leicester; and Dr. R. J. Peters, Deputy Chief Medical Officer, Department of Health for Scotland. We congratulate all three on this well-merited distinction.

#### BOOK REVIEWS

**Domestic Food Consumption and Expenditure, 1950, with a Supplement on Food Expenditure by Urban Working Class Households, 1940-49.** Report by the National Food Survey Committee. (Pp. 131. Price 4s. 6d.) London: H.M.S.O. 1952.

The National Food Survey Committee, which began its operations for the Ministry of Food in 1940, has issued its second report, for the year 1950, following upon the first report, covering the years 1940-1949, which appeared in 1951. The committee under the chairmanship of Norman C. Wright has included among its members Sir Jack Drummond, Dr. H. G. Magee, Miss I. Leitch (Director of the Commonwealth Bureau of Animal Nutrition) and Professor E. F. Nash of the Department of Agricultural Economics, University College of Wales. The tragic death of Sir Jack Drummond occurred after the completion of the second report. The work of the survey committee for the first nine years was chiefly concerned with working class households in the main urban areas of Great Britain and the "sample households" were visited monthly. The national food survey was widened out in 1950 to include all social classes and both urban and rural areas and visits to the samples have been reduced to two each quarter with a quarterly analysis. The classification of social class is by primary income A = £13 a week or over; B = £8-£13 a week; C = £4 10s.-£8 a week, and D = less than £4 10s. The grading so achieved is closely related to occupation, indeed in some instances income has been obtained or inferred direct from occupation. Roughly Class A is Registrar-General's Class I; B is Registrar-General's Class II; C, Registrar-General's Classes III and IV, and D Registrar-General's Class V. Several social stratifications, for the purposes of particular social surveys in Britain, have been devised, as for example that of the Population Investigation Committee and the Merseyside Survey. These in general resemble that of the Registrar-General in being based upon a prestige estimation of occupation. In the circumstances it is to be regretted that the National Food Survey Committee did not adopt the Registrar-General's stratification. This would have helped to relate the findings to morbidity and mortality studies.

In 1950 4,723 households were included in the sample (3,837 urban and 886 rural; of the urban households all but 503 were "working class"). 152 (3%) were in Class A; 603 (13%) in Class B; 2,733 (58%) in Class C and 1,254 (35%) in Class D; of the Class D households 9% were those of old age pensioners. In each household surveyed the housewife was asked to keep a record for one week of all food purchased for the family and of all food from garden and allotments and otherwise obtained without actual cash payment. She recorded a brief description of each meal served and listed any meals taken outside by any member; age, sex, occupation and visitors were also recorded. Visits by specially trained women investigators (employed by an independent firm of market research) preceded by introductory letters were made to explain the use of the log book recording for weight and cost of food. During the week of the survey at least two visits were made to ensure that the housewife was keeping correct records and food stocks were weighed immediately before and after the survey week.

This survey shows that the 1950 diet declined in value (as an annual average) from 21s. 4d. in Class A to 15s. 3d. in Class D (21s. 4d., 18s. 6d., 16s. 2d., 15s. 3d.). A comparison of expenditure on individual foods showed that milk declined from 6.3 pints in Class A, 5.4 in Class B, 4.7 in Class C to 4.4 in Class D, with an average for all households of 4.4 pints; shell eggs declined from 4.2 via 3.9, 3.4 to 3.0 with an all household average of 3.1. Clearly Classes A and B consume substantially more milk and eggs than the other classes. In contrast consumption of meat and fats varied little whereas that of potatoes and bread was much higher in Class D (together 117.0 oz. in Class D, 95.7 oz. in Class A) and that of fresh green vegetables and fruit much lower (expenditure together 12s. 5d. in class D and 27s. 0d. in Class A).

The household diet for 1950, with many and proper reservations, has been compared with that of pre-war days. The broad comparison presented by the 1950 National Food Survey with that of Crawford and Broadley (1936/1937) is as follows: Average food expenditure has risen from 8s. 11d. per week to 14s. 6d. All classes spent more in 1950 on fresh milk, margarine and fresh fruit and slightly more on potatoes, bread and flour. The difference between classes had narrowed considerably (10s. 10d. pre-war falling to 4s. 1d. in 1950). The report says "this substantial reduction in social class differences was achieved largely by the levelling up of expenditure on the part of the lower class." Class D spent more and Class A probably less on eggs, butter, fresh meat and fresh vegetables. In particular Class A spent three times as much as Class D pre-war on eggs, butter and fresh meat, whereas (largely

no doubt on account of rationing) 1950 figures showed little difference. The class differences for milk, fresh vegetables and fruit, although still appreciable in 1950, were much less than before the war. In terms of adequacy of the diet as measured by the B.A.M.'s recommendations the report says that "during the survey period in 1950 all households except those of Class D reached the standard for all nutrients. The whole of class D was below the standard for calories and old age pensioners' households were also below for iron."

The greatest significance should be attached to variations in expenditure on foods of high protective value in households containing varying numbers of children. Prewar surveys, e.g. that in West Sussex (Brockington, *Journal of Hygiene* (1938) 40), showed a marked decline in expenditure on animal protein foods in working class households as the number of children in the family increased. Subsequent surveys (e.g. in Salford and West Riding of Yorkshire during World War II) showed that this adverse circumstance had been much reduced. The National Food Survey findings for 1950 are unfortunately not conclusive on this point since averages are given for all social classes together and the average figures do not allow any precise comparison for working class families with varying numbers of children. Thus, of the households with one adult male and one adult female, those with no children contain 17% of classes A and B, those with one child 21%, those with three children 16% and those with four or more children 8%. With this in mind there is a marked difference for fresh milk, eggs, meat and fresh green vegetables and fruit. Milk declined from 5.5 pints a week in childless couple families to 4.3 pints in families with four or more children; shell eggs from 4.0 to 2.7; fresh rationed meat from 17.3 oz. to 10.1 oz. In contrast butter, margarine and cooking fat together declined from 12.9 to 10.5 oz., potatoes from 64.9 oz. to 59.3 oz., bread from 58.5 oz. to 53.9 oz. In terms of expenditure the average weekly expenditure on food per head fell from 18s. 2d. in childless couple families (excluding old age pensioner households) to 11s. 3d. where there were four or more children under 14 years. The average expenditure rose with the presence of adolescent children to 17s. 7d. (with adolescents only) and 13s. 11d. with adolescents and children.

Although the households with four or more children had the benefit of cheap milk their weekly consumption per head over the year was still less than that of the childless household by as much as 1.2 pints per head per week; during July and August the difference was 1.7 pints per head per week. Over the year childless households consumed an average of 1.2 more eggs per head per week and during the flush season childless households consumed 2.4 more eggs per head per week than those with four or more children. The 1950 survey has converted weight and expenditure figures into an estimate of essential nutrients consumed. In order that a comparison can be made with the B.M.A. (1950) recommendations allowances have been made for spoilage and wastage, age and sex, a weighting included for meals taken away from home and an arbitrary allowance made for work and activity. The following table gives a comparison of the average nutrient value of the diet of childless couple households and those with four or more children (without adolescents):—

Nutrients	Families with more	
	Childless Households	than three children
Energy Value (cal) ..	2,804	2,168
Protein (g.) ..	91	65
Animal Protein (g.) ..	47	30
Fat (g.) ..	118	86
Calcium (mg.) ..	1,212	959
Iron (mg.) ..	15.9	11.3
Vitamin A (i.u.) ..	3,949	3,201
Vitamin B (mg.) ..	1.17	1.33
Riboflavin (mg.) ..	2.17	1.43
Nicotinic Acid (mg.) ..	15.4	10.4
Vitamin C (mg.) ..	102	61
Vitamin D (i.u.) ..	167	201

In terms of the B.M.A. recommendations, the diet of families with over three children was "marginal." Both protein and calcium were below standard at all seasons of the year; vitamin C fell below in April and May; after the lowering of the extraction rate of flour, iron and riboflavin fell below the standard in October and November. The average consumption of most if not all, nutrients must have been raised appreciably by the 8% of class A and B families with four or more children. We are, therefore, left with little doubt that the average diet of working class families with more than three children in 1950 was only on the borderline of sufficiency. The extent of the deficiency in these larger families has clearly declined since prewar days.

Fraser Brockington.

## SOCIETY OF MEDICAL OFFICERS OF HEALTH

### NOTICES

#### MATERNITY AND CHILD WELFARE GROUP Post-Graduate Week-end, London, October 3rd and 4th, 1953

The Maternity and Child Welfare Group will be holding their post-graduate week-end in London on Saturday and Sunday, October 3rd and 4th, 1953. The programme will include lectures on Health Education and Child Psychology and a visit to the Medical Research Council laboratories. The registration fee is £1 ls.

DORIS A. CRAIGMILE,  
Hon. Secretary.  
MARY T. PATERSON,  
Assistant Hon. Secretary.

### REPORTS

#### COUNCIL MEETING

A meeting of the Council of the Society was held in the Council Room of the B.M.A. on Friday, May 22nd, 1953, at 10 a.m.

**Present:** Dr. J. M. Gibson (in the Chair), Dr. Andrew Topping (President), Drs. F. A. Belam, R. T. Bevan, W. H. Bradley, Prof. C. Fraser Brockington, Drs. F. G. Brown, C. Metcalfe Brown, George Buchan, J. S. G. Burnett, H. D. Chalke, Sir John Charles, Drs. T. M. Clayton, H. M. Cohen, H. K. Cowan, C. K. Cullen, Sir Allen Daley, Drs. R. H. G. H. Denham, Miriam Florentin, F. Gray, Kathleen M. Hart, A. S. Nebbethwaite, G. E. Herington, J. H. Hudson, J. Maddison, M. Mitman, J. B. S. Morgan, A. A. E. Newth, Prof. R. H. Parry, Drs. G. H. Pringle, T. Ruddock-West, H. L. Settle, J. F. A. Smyth, Esq., Drs. J. A. Stirling, F. R. Waldron, E. J. Gordon Wallace, W. S. Walton, Nora I. Wattie, Ann Mower White, N. C. Maurice Williams, Prof. G. S. Wilson and Maj. Gen. T. Young. Dr. A. V. Kelyack, Secretary of the B.M.A. was also present.

**Apologies for Non-Attendance** were received from Drs. W. G. Clark, F. M. Day, F. Fenton, J. D. Kershaw, Jean Mackintosh, J. B. McKinney, R. M. Orpwood, Hugh Paul, A. G. Reekie, W. Woolley and J. Yule.

**104. Welcome to New Member.**—A hearty welcome was extended to Maj. Gen. T. Young who was attending a meeting of the Council for the first time.

The Chairman also expressed to Sir Allen Daley the Council's pleasure at welcoming him back after his visits abroad.

**105. Minutes.**—The minutes of the meeting of the Council held on Friday, February 20th, 1953 (*Public Health*, April, pp. 112-114) were confirmed and signed by the Chairman.

**106. Presidency of the Society for the Session 1953-1954.**—The Council received the following nominations for the election of President of the Society for the Session 1953-1954:—

Dr. C. Metcalfe Brown, nominated by the North Western Branch;

Dr. J. D. Kershaw, nominated by the County District Group; Dr. Charles F. White, nominated by the Metropolitan Branch; Dr. J. Greenwood Wilson, nominated by the Welsh Branch.

All the ballot papers, which had been distributed before the meeting, were collected and, on the votes being counted, the Chairman declared that the nomination of Dr. C. Metcalfe Brown, M.O.H. Manchesyer C.B., should be submitted for election by the Ordinary meeting to follow. Dr. Metcalfe Brown briefly thanked the Council for the honour which was to be bestowed upon him.

**107. Officers of the Society for the Session 1953-1954.**—The following were elected Officers of the Society for the Session 1953-1954:—

(a) **Chairman of Council**—Dr. J. M. Gibson.

(b) **Three Vice-Presidents**—Drs. H. C. Maurice Williams, W. G. Clark and Andrew Topping;

(c) **Honorary Treasurer**—Dr. C. Herington.

(d) **Honorary Solicitors**—Messrs. Neish, Howell & Haldane, 47 Watling Street, London, E.C.4.

**108. Co-optation of Members to Serve on the Council for the Session 1953-1954.**—On nominations being invited for the co-optation of members to serve on the Council for the Session 1953-1954, the following names were submitted for ballot at the September meeting of Council:—

**Article 19(d)**—Drs. C. Fraser Brockington, James Fenton, Hugh Paul and J. Greenwood Wilson.

**Article 19(f)**—Dr. George Buchan, Sir John Charles, Sir Allen Daley and Prof. G. S. Wilson.

**109. Presidency of the Society and Chairmanship of Council.**—The General Purposes Committee was asked to consider the advisability of the President of the Society being ex officio Chairman of Council.

**110. Report of the General Purposes Committee.**—Dr. H. K. Cowan presented the report of the meeting of the General Purposes Committee held on Friday, April 17th, 1953 (APPENDIX A):—

*Min. 76. Whitley Medical Functional Council*

(a) *Committee "C"*.—Dr. H. K. Cowan submitted a verbal report on the hearing at the Industrial Court of the claim by the staff side for a revision in the salary scale payable to Departmental Medical Officers.

(b) *Implementation of Awards*.—Dr. A. V. Kelynack reported on the position with regard to the implementation of the awards of the Industrial Court and the appeals which were still outstanding.

*Min. 78. Review of the Finances of the Society*

*Min. 79. Training of Health Visitors*.—It was reported that a meeting of the Sub-Committee had been held on Monday, May 11th, and the first draft of a document for submission to Council was now in course of preparation.

*Min. 8. D.P.H. Committee*.—Prof. R. H. Parry, Chairman of the Committee, reported that a further meeting of the D.P.M. Committee had been held on May 21st and that it was hoped to submit a report at the next meeting of Council.

*Min. 82. Change of name of the Society*.—It was reported that the postal ballot had disclosed that 915 members were in favour of a change of name for the Society and 182 members against. The voting on the actual new name proposed—the Society of Preventive Medicine—showed that 937 members were in favour and 160 against. It was decided to call an Extraordinary Meeting of the Society at 5 o'clock on Friday September 17th, at which the proposal to change the name of the Society could be formally dealt with.

*Min. 86. Medical Reports on Entrants to Training Colleges*.—The Council received a full report of the discussions at the Ministry of Education.

*Min. 90. Slaughterhouses*.—It was reported that Drs. F. A. Belam, W. R. Martine and Charles White and the Administrative Officer had attended a meeting of the Interdepartmental Committee on May 13th to give oral evidence in support of the written evidence already submitted.

*Min. 92. Distribution of Transferable Deaths*.—It was reported that the General Register Office was discussing with the Ministry of Health possible ways of meeting difficulties which had been experienced by certain M.O.s.H. The General Register Office had promised that, as soon as specific proposals were drawn up, the Society would be asked to approve any proposed provision of the present procedure.

*Min. 97. Children with Defective Hearing*.—On the proposition of Dr. Miriam Florentin, it was resolved that the Ministry of Health be informed that the Society was of opinion that consideration should be given to the problem of children under school age who were suffering from defective hearing and that the circular which it was proposed should be issued by the Ministry of Education to Education Authorities should also be issued by the Ministry of Health to Local Health Authorities and Regional Hospital Boards. It was also proposed that steps be taken to arouse the interest of specialists in this field.

*Min. 100. Occupational Health Services*.—The President gave a verbal report on the meeting of the Sub-Committee of the General Purposes Committee which had considered this matter. After hearing this report, it was resolved that the following members of the Society be appointed a Committee to prepare a document setting out the Society's policy covering future occupational health services:—

The President, Drs. A. Brown, J. S. C. Burnett, H. D. Chalke, H. K. Cowan, Stuart Laidlow, W. S. Parker and Llywelyn Roberts.

Subject to the above amendments and additions, the minutes of the General Purposes Committee were received and the recommendations contained therein were adopted.

**111. Adoption of Children Committee.**—(Min. 70).—The Council considered a document which contained draft evidence for submission by the Society to the Committee which had been set up by the Home Office to consider the present law relating to the adoption of children and to report on what changes were desirable in the interests of the welfare of children. It was resolved that the matter be referred to a Committee consisting of Drs. Miriam Florentin, J. B. S. Morgan, A. A. E. Newth and Ann Mower White so that the Society's evidence should agree as far as possible with that already submitted by the B.M.A. The Sub-Committee would also deal with the presentation of oral evidence in support at a meeting of the Home Office Committee on July 2nd.

**112. B.M.A. Public Health Committee.**—It was reported that the usual invitation had been received from the B.M.A. for the Society to appoint two members to serve on the Public Health Committee of that organisation. It was resolved that Dr. H. D.

Chalke and Llywelyn Roberts be appointed the Society's representatives.

**113. Outbreaks of Communicable Diseases in Hospitals.**—The attention of members was drawn to Circular RHB(53)40 which emphasised to Hospital Authorities the need in keeping the Medical Officer of Health of the district concerned fully informed of outbreaks of communicable diseases in hospitals.

**114. Provision for Accommodation for Medical Inspection in Schools.**—It was reported that the Yorkshire Branch of the Society had considered Section 13 of Standards for School Premises Regulations, 1951 and had resolved to request the Council of the Society to consider an approach being made to the Ministry of Education to secure the provision of a suitable special room or rooms for medical inspections in all new schools irrespective of size. The resolution had already been referred to the School Health Service Group for consideration and the Yorkshire Branch had provided further information which could be used as evidence should the Society eventually decide to take the matter up with the Ministry of Education. Dr. Newth reported that the School Group would consider this matter at its next meeting and that a recommendation would be made to the Council of the Society in due course.

It was resolved also that the Dental Officers Group be asked to consider this matter.

**115. Ministry of Education Circulars.**—It was reported that the Yorkshire Branch had also considered the question of Ministry of Education Circulars and were of opinion that Circulars which related to the School Health Service should be addressed directly to School Medical Officers in lieu of the existing practice whereby they were sent to the Education Officer for further distribution. It was agreed that this matter should also be considered by the School Health Service Group at its next meeting.

**116. British Postgraduate Medical Federation.**—A letter dated April 27th was received from the Director of the British Postgraduate Medical Federation which referred to the responsibility of the Federation which referred to the responsibility of the Federation for providing, on behalf of the University of London, continuing education for general practitioners in the four metropolitan regions. The Federation had been impressed by the need to encourage closer co-operation between the general practitioners, the consultant staffs of hospitals and Medical Officers of Health and sought the advice of the Society on how this could be effected. It was resolved that the Federation be informed that Medical Officers of Health would be very willing to assist in any way they could to further this closer co-operation. The Society felt that one of the best ways of encouraging this end would be for a Public Health Officer to be asked to take some part in the organising of the various courses so that, apart from the lectures, the students on the course could spend some small part of their time witnessing some of the public health activities in the locality in which the course was being held.

**117. Slaughtering Trade—Apprenticeships.**—A Letter dated April 29th from the National Association of Youth Employment Officers sought the advice of the Society concerning the advisability of the employment of boys between the ages of 15 and 17 in the occupation of slaughtering. It was resolved that the Association be informed that the Society did not feel that it could suggest the introduction of any limitation on the ages of those concerned. Members present did not feel that there was any great risk to the mental or physical development of the youths in question.

**118. Hospital Service Statistics.**—The attention of members was drawn to Circular RHB(53)43 which described arrangements for notifying Local Health Authorities of details of prematurely born infants treated in hospitals.

**119. Foot Deformity in Children.**—A letter dated May 4th from Mr. C. A. Pratt drew the attention of the Society to his letter in the *Lancet* of April 11th, 1953 and asked the Society to approach the Ministry of Health so that immediate and effective action could be taken to reduce the incidence of foot deformity in children. It was resolved that no action be taken on the letter other than to inform Mr. Pratt that the Foot Health Educational Bureau were already collecting evidence so that consideration could be given to this matter.

**120. The Cost of the National Health Service.**—A letter dated May 20th from the Secretary of the Committee of Enquiry into the Cost of the National Health Service invited the Society to submit evidence on matters within the terms of reference of the Committee. It was resolved that a drafting Sub-Committee, whose membership would be the President, Drs. G. F. Buchan, H. K. Cowan, Sir Allen Daley, Drs. Hamilton Hogben and Maurice Mitman, be appointed to prepare evidence to be submitted by the Society.

**121. Detergents.**—The attention of members was drawn to the statement of the Minister of Housing and Local Government in the House of Commons regarding the setting up of a Committee to

examine the effects of the increasing use of synthetic detergents. In view of the membership of that Committee, it was agreed that the public health aspect of the matter would be carefully watched and therefore the Society would not submit formal evidence to the Committee.

**122. Rehabilitation of Disabled Persons.**—It was reported that a Committee of Inquiry on the Rehabilitation of Disabled Persons had been set up by the Minister of Labour and National Service, the Minister of Health and the Secretary of State for Scotland. It was agreed that the Society would not submit formal evidence until it was specifically invited so to do.

**123. Tuberculosis Standing Advisory Committee.**—A letter dated May 18th from the Tuberculosis Group asked the Society to approach the Ministry of Health to endeavour to secure the appointment of a larger proportion of men actually engaged in tuberculosis work, particularly in clinical work in the field as members of the Tuberculosis Standing Advisory Committee of the Central Health Services Council. It was agreed that a letter be addressed to the Ministry of Health on this matter.

**124. Matrimonial Disputes—the Position of the Health Visitor.**—A letter dated May 15th from the Women Public Health Officers Association sought the views of the Society on the position which would arise if Health Visitors were called to give evidence in cases of matrimonial disputes in the families amongst whom they were working. It was agreed that a suitable reply be forwarded to the Association.

**125. Representation.**—It was resolved that the following be appointed the representatives of the Society on the occasions named:—

- (a) *Sanitary Inspectors Association*—Annual Conference, Morecombe, September 8th-11th. Dr. Andrew Topping.
- (b) *Royal Sanitary Association of Scotland*—Annual Congress, Perth, September 28th-October 2nd. Dr. J. Greenwood Wilson.
- (c) *National Smoke Abatement Society*—Annual Conference, Glasgow, September 30th-October 2nd. Dr. Stuart Laidlaw.
- (d) *National Housing and Town Planning Council*—Annual Planning Conference for the London Region, Tuesday, June 30th. A member of the Metropolitan branch.
- (e) *R.S.I. Committee on Fluorides in Water Supplies*. Mr. Jeffrey Fletcher.
- (f) *British Standards Institute*—Technical Committees to consider plans for cleansing and sterilising equipment for use in hospitals. Dr. Maurice Mitman.

**126. Life Membership.**—The following recommendations for life membership of the Society from the Branches named were confirmed for submission at the next Ordinary Meeting of the Society:—

*Home Counties Branch*—Dr. G. Leonard Williams, formerly M.O.H. Barking M.B. (Joined the Society in 1921.)

*North Western Branch*—Prof. W. M. Frazer, formerly M.O.H. Liverpool C.B. (Joined the Society in 1923.)

There being no other business, the meeting was declared closed at 12.30 p.m.

#### APPENDIX A

A meeting of the General Purposes Committee was held in the Committee Room of the Society on Friday, April 17th, 1953, at 10 a.m.

**Present:** Dr. H. K. Cowan (in the Chair), the President (Dr. Andrew Topping), Chairman of the Council (Dr. J. M. Gibson), Drs. H. D. Chalke, C. K. Cullen, Miriam Florentin, Maurice Mitman, A. A. E. Newth, T. Ruddock-West, J. F. A. Smyth, Esq., Drs. J. A. Stirling and W. S. Walton.

Dr. A. V. Kelynaek, Assistant Secretary of the B.M.A. was also present.

**Apologies for Non-Attendance** were received from Drs. W. G. Clark, F. M. Day and James Fenton.

**74. Minutes.**—The minutes of the meeting of the Committee held on December 12th, 1952 (*Public Health*, pp. 114-116) were confirmed and signed by the Chairman.

**75. Dr. James Fenton.**—It was resolved that a letter be forwarded to Dr. James Fenton, who had recently undergone an operation, wishing him a rapid and complete recovery.

**76. Whitley Medical Functional Council (Min. 22).**—

(a) **Implementation.**—Dr. A. V. Kelynaek reported verbally on the position of various appeals that had been heard or were pending.

(b) **Committee "C."**—It was reported that the hearing of the claim for increased salaries for Medical Officers in Departments was to be held by the Industrial Court on May 13th and that a dispute would probably be declared between the Divisional Medical Officers of Co. Down and the Northern Ireland Ministry of Health regarding the recognition of those Officers as Divisional Officers within the terms of the awards of the Industrial Court.

**77. Abolition of the Fever Register (Min. 37).**—The Chairman of Council, Dr. J. M. Gibson, gave a verbal report on the discussions at the Ministry of Health between representatives of the Society and the Ministry at which objection was made to the proposed abolition of the Fever Register. The deputation had had a sympathetic hearing and it was hoped that the Minister would consider favourably the representations made by the Society.

It was further reported that Dr. Maurice Mitman had attended a meeting on April 1st between representatives of the B.M.A. and of the Royal College of Nursing, at which this question was also considered. At this meeting, the Royal College of Nursing had maintained the principle that all the special registers should go and it appeared that the College viewed the whole matter from the point of view of examinations only. Dr. Mitman had pressed the point that, at any rate, the special register for fever nurses should not be abolished until alternative services were available and it had been agreed that the Minister be asked to wait for the collection of statistics as to the decline of recruitment to this section of the service before making any decision in the matter.

**78. Central Office Staff (Min. 28).**—It was reported that, at the last meeting of the Council, the recommendations of the Committee had been approved, subject to the undertaking given by the Chairman and the Hon. Treasurer that a complete review of the Society's financial position and staffing and work of the Central Office be made within the next twelve months. It was resolved that Dr. C. E. Herington, the deputy Treasurer, be co-opted a member of the General Purposes Committee so that he could act with the Treasurer and Chairman in drafting a report for ultimate submission to the Council.

In this connection, the following resolution from the Yorkshire Branch was received:—

"The Yorkshire Branch urges the Council of the Society to appoint an experienced Medical Officer of Health as whole-time Medical Secretary at a commencing salary equivalent to that of a Medical Officer of Health of a large Local Health Authority and to take the necessary measures regarding the annual subscription and the staffing of the Central Office to effect this."

It was resolved to recommend to Council that the Branch be informed that it was out of the question to implement the recommendation in view of the cost involved and the very large increase in the subscription rate for membership which would be necessary.

**79. Training of Health Visitors (Min. 35).**—It was reported that, on February 20th, a further conference with representatives of the Royal College of Nursing, the Women Public Health Officers' Association, the Standing Conference of Health Visiting Training Centres and the Society, was held at which it was decided that no further action be taken on the suggested distribution of a form of questionnaire to all Health Visitors. The conference had agreed instead that the Ministry's Working Party, when set up, be urged to use the form of questionnaire which was agreed at the meeting.

**80. Prescription Fees for Lymph (Min. 42).**—A letter dated March 20th from Sir John Charles informed the Society that there could be no exemptions from the payment of the shilling prescription charge. The National Assistance Board could refund the charge in certain cases as also could the Ministries of Pension and National Insurance. The letter had also pointed out that doctors taking part in Local Health Authority arrangements under Section 26 of the N.H.S. Act could obtain lymph and diphtheria prophylactic free of charge from the Public Health Laboratory Service or from the Medical Officer of Health. It was resolved that a paragraph be published in *Public Health* requesting all Medical Officers of Health to bring these arrangements to the notice of all General Practitioners.

**81. D.P.H. Committee (Min. 53).**—It was reported that a letter had been addressed to the B.M.A. supporting the views expressed by the Occupational Health Committee that there should be closer integration of the courses for the D.P.H. and D.I.H.

**82. Change of Name of the Society (Min. 54).**—It was reported that, at the time of the meeting, 900 members had voted in favour of a change of name for the Society and 182 against. 922 members were in favour of the new name proposed and 160 against. In this connection, a letter had been received from the East Anglian Branch containing the following resolutions:—

1. It was proposed, seconded and carried by a majority that "This Branch strongly opposes any change in the name of the Society."

2. It was proposed, seconded and carried nem con, that "Even if there is a majority in favour of a change of name, this Branch strongly object to the proposed name 'The Society of Preventive Medicine,' and is of the opinion that no alternative name should be adopted until there has been

full opportunity for it to be considered by the Branches and the Groups of the Society as a whole."

3. It was proposed, seconded and carried nem con, that "This Branch deplores the manner in which the proposal to change the name of the Society has been dealt with, without having been referred to all the Branches and all the Groups of the Society for discussion."

It was resolved that these resolutions be received.

**83. Health, Welfare and Safety in Non-Industrial Employment (Min. 55).**—It was reported that it was hoped to call a meeting of the Sub-Committee in the near future.

**84. Slaughter of Horses (Min. 60).**—The Committee received and endorsed a copy of the evidence submitted to the Ministry of Health.

**85. "British Medical Journal" (Min. 62).**—The Chairman reported an interview he had had with the Deputy Editor of the *B.M.J.* in which he had pointed out the Society's concern at certain items which had recently appeared in that Journal.

**86. Medical Reports on Entrants to Training Colleges (Min. 63).**—Dr. Newth reported that representatives of the School Health Service Group had attended at the Ministry of Education on April 15th to discuss the procedure adopted for dealing with medical reports on entrants to training colleges. It appeared that the Ministry were to take administrative action to overcome the objections made by the School Health Service Group.

**87. Civil Defence (Min. 65).**—The Committee considered a letter from the Yorkshire Branch dated January 5th which requested the Society to approach the Ministry of Health with a view to the role of the Medical Officer of Health in Civil Defence being more clearly defined and Dr. W. S. Walton kindly undertook to prepare a draft of a letter to be forwarded to the Ministry of Health for consideration at the next meeting of the Committee.

**88. Milk Bottles (Min. 67).**—Representatives of the Central Milk Distributive Committee attended to discuss the problems in the milk industry of dirty and broken bottles. Following a general discussion of the matter the representatives were asked to write giving details of suggested action by the Society. In the meantime, it was resolved to recommend that School Medical Officers be invited to encourage more attention being paid to the care of milk bottles in schools.

**89. Public Health Service Defence Trust.**—It was reported that, following the last meeting of the Committee, a letter had been received from the Secretary of the Trust asking the Society's help in making personal contact with individual members of the public health service so that they could be encouraged to support the Trust especially by prompt payment of contributions.

The Chairman and Secretary of the Trust had discussed with the Administrative Officer the ways in which the Society could help in this matter.

**90. Slaughterhouses.**—A letter dated March 13th from the Ministry of Food referred to the appointment of an Interdepartmental Committee to prepare a plan for the control and provision of slaughterhouses and sought the Society's advice on certain principles which should be considered by the Committee in formulating recommendations to the Minister. The letter had been referred to the individual members of the Standing Sub-Committee for Food Matters who had forwarded certain recommendations. It was resolved that the Society forward comments to the Ministry in the form attached.

**91. Research Committee.**—The minutes of a meeting of the Research Committee held on March 31st were received.

**92. Distribution of Transferable Deaths.**—It was reported that there had been some criticism of the new procedure outlined in the revised memorandum on the distribution of transferable deaths and that difficulties had been experienced by several M.O.s H. It appeared that the Registrar General had already had the points raised drawn to his attention and that arrangements would shortly be made to amend the procedure.

**93. Artificial Sweetening Agents.**—It was reported that a letter dated March 31st from the Ministry of Food had given details of the proposed order to prohibit the inclusion in food of certain artificial sweetening agents and sought the Society's comments on the proposals. The letter had been referred to the Standing Sub-Committee on Food Matters and on their advice the Ministry had been informed that the Society had no comments to make on the proposals.

**94. Absence from School.**—It was reported that the Central Council for Health Education had asked whether the recommendations contained in an article in the March issue of *Better Health*, regarding the advice to be given to parents on the advisability of keeping children away from school in certain circumstances, were generally agreed by Medical Officers of Health. They also wished to know whether a leaflet on this matter would be acceptable if it were published. It was resolved that the Central Council for

Health Education be informed that the Society did not consider it advisable at the moment to issue a memorandum of this nature.

**95. Annual Report of M.O.H.**—The attention of members was drawn to the Annual Report of a Medical Officer of Health, part of which had been signed first by the Clerk to the Divisional Health Committee and secondly by the Medical Officer as Divisional Medical Officer. It was resolved that a letter be addressed to the Medical Officer of Health concerned to ask for his comments.

**96. Resettlement of Tuberculous Persons in Industry.**—A letter dated March 9th from the B.M.A. informed the Society that, as a result of the discussions between representatives of the Public Health, Occupational Health and Tuberculosis Group Committees of the B.M.A., a request had been sent to the Ministry of Health for a deputation from the Association to be received to discuss various important questions raised in the proposed scheme. It was noted that the three representatives of the joint conference included Dr. H. K. Cowan, Chairman Public Health Committee.

**97. Children with Defective Hearing.**—A letter dated March 13th from the Ministry of Education had enclosed copies of a draft circular on children with defective hearing and sought the comments of the Society on the proposals. The letter had been referred to the School Health Service Group and the Committee considered a draft document to be forwarded to the Ministry. It was resolved that the document be endorsed and forwarded as the Society's official comments in the matter.

**98. Staff Pension Scheme.**—It was reported that, following the recent changes in the staffing of the Central Office, it had become necessary to terminate the pension scheme which had been operated for the benefit of Mr. G. L. C. Elliston. It was resolved that, for the purposes of the scheme, the present arrangements be deemed a technical dismissal of Mr. Elliston in consequence of reorganisation and that, under Clause 12 of the agreement between Mr. Elliston and the Society,

(a) A portion of the Society's bond be retained until Mr. Elliston reached the age of 65 when the pension covered by the payment of premiums to date would become payable to him, estimated to amount to £76 16s. 8d. per annum, and an immediate cash payment of £765 8s. being made (the surrender value of the remainder of the bond).

(b) The endowment policy, the premiums for which had been met by deductions from Mr. Elliston's salary, be assigned to him so that he could continue to pay the premiums as a personal responsibility.

**99. National Survey of the Health and Development of Children.**—It was reported that the Committee responsible for this Survey had produced a report entitled "Maternity in Great Britain, 1948" and, in view of the fact that there were a number of the copies unsold, they were offered for disposal to Societies and other bodies at the reduced price of 7s. 6d. each. The books could be obtained from the London School of Economics, Houghton Street, W.C.2.

**100. Industrial Health Service.**—A draft memorandum to the Ministry of Labour and National Service prepared by the Standing Sub-Committee of the Occupational Health Committee on the future occupational health service was received for consideration by the Society in accordance with the terms of the agreement with the B.M.A. It was resolved that, since this document had not been received in time for perusal by members before the meeting, the question being referred to a Sub-committee consisting of the President, Drs. H. D. Chalke and H. K. Cowan.

**101. Notification of Infectious Disease.**—A letter dated April 14th from Sir John Charles referred to the communication received from the Society on the subject of suggested amendments to the list of notifiable diseases and invited representatives to attend at the Ministry for discussions on this subject. It was resolved that the Chairman of Council, Dr. J. M. Gibson, Drs. Maurice Mitman and Hugh Paul be appointed the Society's representatives in this matter.

**102. Annual Dinner.**—It was agreed that the annual dinner of the Society be held at the Piccadilly Hotel on Thursday, October 22nd, 1953.

**103. Representation.**—

(a) *British Council for Rehabilitation.*—It was resolved that Dr. A. A. E. Newth be appointed the Society's representative.

(b) *Institute of Public Administration.*—It was reported that the Institute of Public Administration had been making arrangements for a second conference on the administrative problems of the National Health Service and had invited the Society to appoint a representative to attend the meeting of the Organising Committee which had been held on April 14th. The action of the Administrative Officer in arranging for Dr. H. C. Maurice Williams to attend on the Society's behalf was confirmed.

There being no other business the meeting was terminated at 12.30 p.m.

## ORDINARY MEETING

An Ordinary Meeting of the Society was held on Friday, May 22nd, 1953, in the Council Room of the B.M.A., Tavistock House, Tavistock Square, W.C.1. The President (Dr. Andrew Topping), was in the chair and there were also present approximately 45 members.

**1. Minutes.**—The minutes of the Ordinary Meeting held on April, 1953, (*Public Health*, May, p.128) were confirmed and signed by the chairman.

**2. Election of the President for the Session 1953-1954.**—The Chairman of Council reported that, under Article 17 of the Society's Articles of Association, the name selected by the Council for nomination as President of the Society was Dr. C. Metcalfe Brown, M.O.H. Manchester C.B. The meeting unanimously elected Dr. Metcalfe Brown, who briefly returned thanks for the honour given to him. He was congratulated by several members present.

**3. Elections.**—The following candidates, having been duly proposed and seconded were then elected to membership:—

Drs. Dorothy J. Ball, Alice I. Burke, H. Diggles, Agnes D. Donaldson, T. L. Dunn, Katherine L. Harries, Mary A. Hield, Lorraine C. Lawrence, I. B. Millar, W. T. Orton, Eluned M. Puleston-Jones, Mary M. Sellar, H. G. Skinner, Ruth R. Stoakley and M. Ormiston.

The meeting then terminated.

## EAST MIDLAND BRANCH

*President:* Dr. J. B. S. Morgan (C.M.O.H., Derbyshire).

*Hon. Secretary:* Dr. J. A. Stirling, D.S.C. (M.O.H., Chesterfield, M.B.).

A meeting of the Branch was held in the Guildhall, Nottingham, on Thursday, March 12th, 1953, the President in the chair and 18 members present.

Dr. Morgan referred to the sad loss sustained by the Branch by the death of Dr. J. A. Kerr, Medical Officer of Health, Grimsby. He paid a high tribute to the valuable service rendered to the Branch by Dr. Kerr and the members present stood in sympathy and affectionate remembrance.

A discussion was opened by Dr. Milner, Medical Superintendent, Aston Hall Mental Deficiency Institution and Mr. Waincott, Senior Mental Health Social Worker, Derbyshire County Council on "The Mental Health Services." Both speakers dealt with the subject in a most interesting, instructive and stimulating manner and that their remarks were appreciated was shown by the full discussion which followed and at the conclusion of which they were warmly thanked by the President.

A meeting of the Branch was held in the Guildhall, Nottingham, on Thursday, April 9th, 1953—the President in the chair and 15 members present.

The Branch decided to support the nomination of Dr. C. Metcalfe Brown for the Presidency of the Society for the Session 1953-54.

Dr. B. C. Humphreys opened a discussion on Ministry of Health Circular 5/53 with particular reference to (a) discharge of patients from Maternity Hospitals and, (b) the Local Health Authority and Midwives in Maternity Hospitals. She dealt exhaustively with the subject which was followed by a keen discussion at the conclusion of which Dr. Humphreys was warmly thanked by the President.

An evening meeting of the Branch was held in the Health Department, Newark, on Thursday, May 14th, 1953—the President in the chair and 33 members present.

Dr. A. I. Ross gave a talk on "The Prevention of Food Poisoning due to Pressed Meat Products." He described several outbreaks in Leicester and went on to describe the steps being taken by the Leicester City Health Department to educate the staffs engaged in preparing pressed meat products. He gave much useful information and the value of his talk was enhanced by numerous lantern slides illustrating his points and, after the discussion which followed he was warmly thanked by the President. (This paper will appear in full in a later issue of *Public Health*.)

Refreshments were taken at the conclusion of the meeting and Dr. and Mrs. Buchanan were warmly thanked for making such excellent arrangements both as regards the meeting and the refreshments.

## NORTHERN BRANCH

*President:* Dr. H. J. Peters (M.O.H., Stockton on Tees, M.B.).

*Hon. Secretary:* Dr. W. S. Walton, G.M. (M.O.H.).

A meeting of the Northern Branch was held at the Fleming Memorial Hospital, Newcastle-upon-Tyne, on Friday May 8th, 1953. Dr. A. S. Hebblethwaite was in the chair in the absence of the President; and 22 members and 1 visitor attended.

**1. Illness of President.**—The Secretary reported that the President was making progress and had expressed his thanks for the Branch's good wishes. Arrangements for the Summer Meeting and the Annual Dinner were left to the Secretary.

**2. Newcastle Medical Journal.**—A request had been received for suitable articles for publication in the *Newcastle Medical Journal* and also for a copy of the Branch minutes. The action of the Honorary Secretary in agreeing to arrange for a write-up of guest speaker meetings and to furnish a copy of the minutes, was confirmed.

**3. Regional Hospital Board.**—Dr. J. B. Tilley was nominated as the Branch's representative on the Medical Advisory Committee of the Regional Hospital Board.

**4. Social Fund.**—The Honorary Secretary stated that members had contributed £5 15s. 0d. to the Social Fund. He would be glad to receive further contributions.

**5. Symposium on Atomic Warfare and Casualties.**—A series of talks on Atomic Warfare and Casualties were given by Dr. A. S. Hebblethwaite (Sunderland), Dr. W. S. Walton (Newcastle-upon-Tyne), and Dr. J. Grant (Gateshead), all whom had attended the Course in Atomic Warfare at Alverstoke, for Medical Officers.

Each speaker dealt with a particular aspect of the problem. In broad terms Dr. Hebblethwaite described the chain reaction brought about by the splitting of atoms, the principle of an atomic bomb explosion, the production of radioactive isotopes and the principle underlying the hydrogen bomb.

The effect of an atomic explosion, i.e., blast, heat flash and gamma rays were then described by Dr. W. S. Walton. He later spoke on Civil Defence organisation, dealing particularly with the comparatively unimportant duties allocated to the local authorities' service.

Dr. Grant's talk dealt more in detail with the various effects of an atomic explosion on personnel, including the treatments which would be necessary.

## NORTH WESTERN BRANCH

*President:* Dr. K. K. Wood (M.O.H. Bury C.B.).

*Hon. Secretary:* Dr. J. S. G. Burnett (M.O.H., Preston, B.C.).

An ordinary meeting of the Branch was held at Manchester Town Hall on Friday, April 10th, at 3.0 p.m. when 18 members attended.

It was resolved that Professor W. M. Frazer, sometime Medical Officer of Health of the City of Liverpool be recommended to the Council of the Society for honorary life membership.

## Comparative Mortality Rates

Dr. C. Metcalfe Brown then opened a discussion on this subject. Reference was first made to the significance of the various forms of death rate in use and to the fact that, after appropriate adjustments, as was well recognised the south and south-east appeared to be more healthy than the north and especially the north-east.

Consideration was then given to some of the characteristics of the two regions in an attempt to ascertain potential causes of the difference. The influence of temperature and humidity were discussed and reference made to smoke pollution and the production of fog. Housing conditions, including congestion of dwellings, the high proportion of defective buildings, the more intense industrial development and the presence of the heavier industrial occupations were thought to be related to heavier mortality.

Specific remedies suggested were slum clearance and the repair and improvement of substandard houses, the reduction of congestion of buildings by sound town planning, the continued improvement of working conditions in factories, offices and shops, the elimination of atmospheric pollution and the constant application of health education methods.

Above all it was considered that morbidity and mortality in the family depended largely on the competence and wisdom of the mother and the environmental conditions in which she established and conducted the home.

The President in congratulating the speaker on his address referred to the urgent need for action against atmospheric pollution as one of the biggest immediate problems. Nutrition appeared to him to play a large part and the dietary habits of the population varied considerably from place to place.

Dr. Wade referred to the considerable variations that existed in adjacent local areas and to the possible influence of racial factors and habits of work.

Dr. Simpson referred to genetic differences and illustrated his remarks with extensive statistical data analysing the causes of death in both the north and south regions.

Dr. Yule in congratulating the speaker on behalf of the assembled audiences thought Dr. Brown had done us a great service in bringing us back to earth and to the things that matter. Much still remained to be done in the older fields of public health and the opportunity was there for those who sought to take advantage of it.

### YORKSHIRE BRANCH

*President* : Dr. J. Wood-Wilson (Deputy C.M.O.H., West Riding).

*Hon. Secretary* : Dr. H. L. Settle (M.O.H., Doncaster C.B.).

An ordinary meeting of the Branch was held on April 24th at the Department of Preventive Medicine, Leeds University, when Dr. Elenora J. Simpson, member of the Branch and Assistant Medical Officer, Maternity and Child Welfare, Halifax, gave a paper on "The Future of Child Welfare Clinics" (which is printed on other pages of this issue of PUBLIC HEALTH).

The paper stimulated much discussion amongst the members of the Branch.

### Whooping-cough Immunisation

An ordinary meeting of the Branch was held on May 29th at the Department of Preventive Medicine, Leeds University, when Dr. W. Charles Cockburn, of the Epidemiological Research Unit, Central Public Health Laboratory, London, gave an interesting paper on whooping-cough immunisation. The speaker reviewed results to date of the field trials with various whooping-cough prophylactics, and pointed out that whooping-cough is still a very important disease. Dr. Cockburn then reviewed the history of whooping-cough immunisation since its introduction in 1923. The difficulty of standardising the potency of the vaccines was stressed; at present no simple laboratory test is available for this purpose. Recent work on production of vaccines from organisms grown in fluid medium without blood protein was also mentioned.

The speaker then dealt with the present position regarding whooping-cough immunisation from the point of view of the Medical Officer of Health, including contra-indications to whooping-cough immunisation. Combined whooping-cough and diphtheria immunisation was considered in detail and finally the speaker discussed the position of booster doses in whooping-cough immunisation.

An interesting discussion followed the paper in which many members took part. A hearty vote of thanks was proposed by Dr. Bradshaw, Deputy Medical Officer of Health, Leeds, who has co-operated closely with Dr. Cockburn in some of the field trials referred to in the paper.

### COUNTY DISTRICT GROUP

*President* : Dr. J. D. Kershaw (M.O.H., Colchester M.B.).

*Hon. Secretary* : Dr. G. H. Pringle (M.O.H., Worthing M.B.).

### Annual Meeting, 1953

The annual meeting of the Group was held at the Priory Street Institute Hall, Hastings, on Thursday, April 30th, at 8.15 p.m. The President was in the chair, and there was an attendance of 130 members.

*Combined and Mixed Appointments.*—The Hon. Secretary reported that this matter had been considered by the General Purposes Committee of the Society, and that the Administrative Officer had reported that the Committee did not propose to take any action on the matter for the time being as it was understood that the subject was already under a reconsideration.

Mr. Bragg was present at the meeting and gave further details for the information of members.

*President's Report.*—The President commenced with a tribute to Dr. Leonard Williams, the immediate Past-President, who had now retired and who was therefore absent from the Annual R.S.I. Congress for the first time for many years.

In a general review of the activities of the Group the President noted that in some areas the Sub-Groups were flourishing although this was by no means general. The general meeting at Birmingham in September had been poorly attended, despite the unanimous request for such a meeting at the Group's annual meeting the previous year.

Preliminary arrangements were in hand to hold a Refresher Course in London in September.

The President then mentioned various matters that had been referred to the Council of the Society during the year, and he also dealt briefly with the memorandum on Decentralisation of Part III Services.

*Report of Hon. Treasurer.*—The Hon. Treasurer's balance sheet was submitted and approved.

*Election of Officers.*—The following Officers were elected for the year 1953-54 :—

*President.*—Dr. F. A. Belam (M.O.H., Guildford M.B.).

*Vice-President.*—Dr. F. W. Campbell Brown (M.O.H., Hyde M.B.).

*Hon. Secretary and Treasurer.*—Dr. G. H. Pringle (M.O.H., Worthing M.B.).

*Hon. Assistant Secretary.*—Dr. J. H. Hudson (M.O.H., Dartford).

*Executive Committee.*—*Ex-officio* : The President, Vice-President, Hon. Secretary and Hon. Assistant Secretary.

The following members, having been nominated by Sub-groups, were elected :—

### Sub-group

Northern ...	Dr. A. Forster and Dr. S. Ludkin.
North-Western ...	Dr. R. E. Robinson and Dr. J. G. Hailwood.
Yorkshire ...	Dr. A. L. Taylor and Dr. Wm. Ferguson.
Midland ...	Dr. J. R. Preston
East Midland ...	Dr. H. L. Barker and Dr. G. G. Buchanan.
East Anglian ...	Dr. J. C. Johnston
Home Counties ...	Dr. C. E. Herington and Dr. F. G. Brown.
Welsh ...	Dr. J. Alun Evans
West of England ...	Dr. J. Menzies Cormack
Southern ...	Dr. J. Sleigh and Dr. E. J. Gordon Wallace.

In addition it was unanimously agreed that the names of Drs. Kershaw and Stirling be added.

The Hon. Secretary reported that at a meeting of the Executive Committee held earlier in the week it had been decided that where a Sub-group has only one representative a deputy may attend meetings if the elected member is unable to be present.

*Matters for General Discussion.*—The following matters, most of which had been put forward by Sub-groups, were discussed :—

(a) Attendance at R.S.I. meetings.

(b) The Haemolytic Streptococcus and Public Health. Owing to the wide variations of procedure as regards methods of dealing with contacts, disinfection, etc., it was recommended that this might be embodied in the Refresher Course.

(c) Superannuation of Medical Officers in the Public Health Service.

(d) Circular F.E.297 of Ministry of National Insurance. Referred to the Executive Committee for clarification.

(e) Death certificates used by Coroners. Difficulties of classification. Referred to the Executive Committee.

(f) M.D.C. Circular No. 16. The Hon. Secretary was asked to send a recommendation concerning whole-time service to the Society's Administrative Officer.

(g) Proposed change of name of the Society.

### A ROLL OF HEALTH VISITOR TUTORS

For the guidance of local authorities and other bodies responsible for the appointment of tutors in health visitor training centres, and with a view to emphasising the need for a high standard of qualification among such tutors, the Royal College of Nursing, at the request of the Standing Conference of Representatives of Health Visitor Training Centres approved by the Ministry of Health, has agreed to set up a roll of health visitor tutors. Applicants must either hold the Health Visitor Tutor Certificate of the Royal College of Nursing or have had such practical and teaching experience as the Council of the College may deem adequate.

### THE ROYAL SANITARY INSTITUTE

Dr. H. C. Maurice Williams, O.B.E., M.O.H. & S.M.O., Southampton C.B. & Port, and President of the Society, 1949-50, has been elected Chairman of Council of the Institute for 1953-54.

The annual Health Congress in 1954 will be held in Scarborough from April 27th to 30th, inclusive.

**Public Health** is the Official Organ of the Society of Medical Officers of Health and a suitable medium for the advertisement of official appointments vacant in the health service. Space is also available for a certain number of approved commercial advertisements. Application should be made to the Executive Secretary of the Society, at Tavistock House South, Tavistock Square, W.C.1.

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PUBLIC HEALTH DEPARTMENT

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Applications are invited for the appointment of a HEALTH VISITOR. Applicants must possess S.R.N. and S.C.M. certificate and must have the Health Visitor's certificate of the Royal Sanitary Institute.

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TREVOR T. JONES,  
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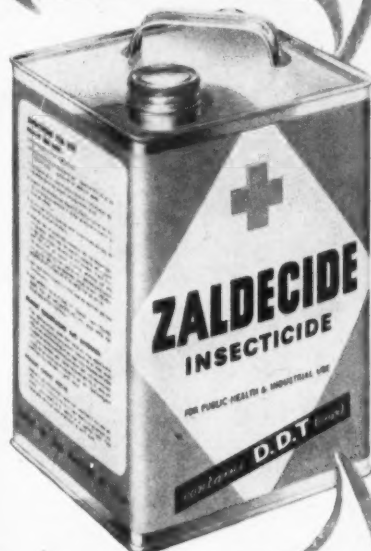
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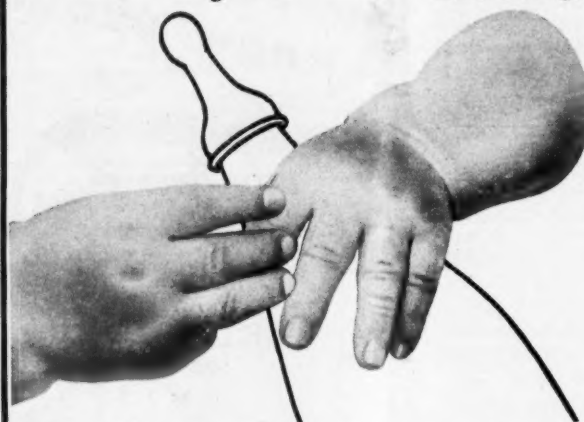
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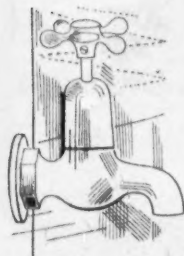
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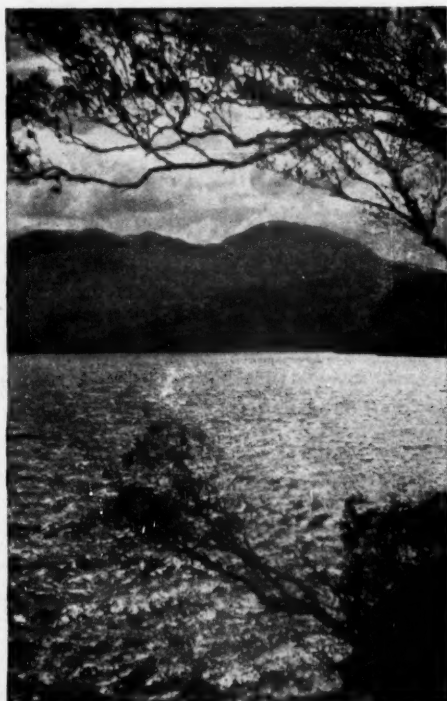
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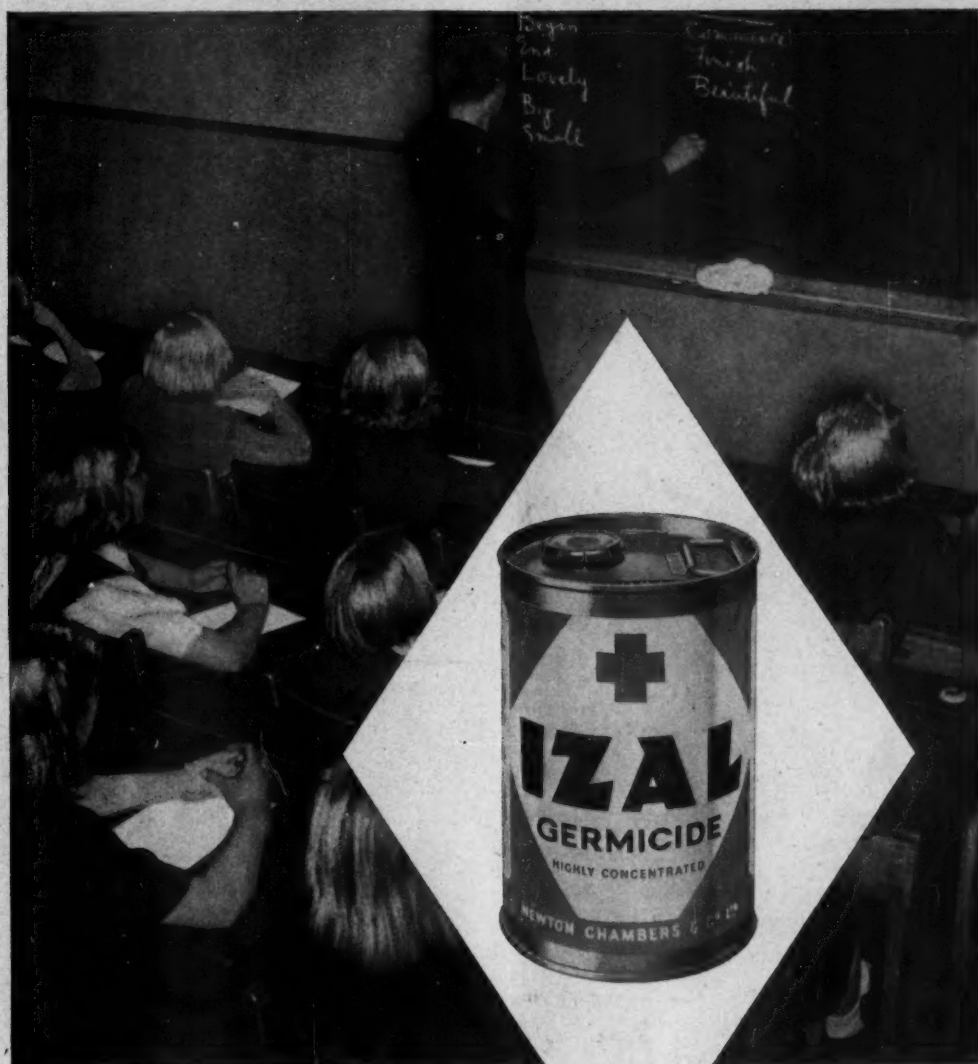
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